

REVIEW SECTION

National and International

Crippled Children and Animals

Review Articles

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Digests

Abstracts

Events and Comments

Rehabilitation Literature is intended for use by professional personnel and students in all disciplines concerned with rehabilitation of the handicapped. It is dedicated to the advancement of knowledge and skills and to the encouragement of co-operative efforts by professional members of the rehabilitation team. Goals are to promote communication among workers and to alert each to the literature on development and progress both in his own area of responsibility and in related areas.

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REHABILITATION LITERATURE

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REHABILITATION LITERATURE

Article of the Month

Social Research in Rehabilitation or One Researcher's Camelot

Milton D. Graham, Ph.D.

About the Author . . .

Dr. Graham has been director of the Division of Research and Statistics of the American Foundation for the Blind since 1958. Prior to this Dr. Graham served as project director in research concerned with human relations at Yale University and as executive secretary of a study group for the U.S. Department of Defense's Research and Development Board. A graduate of Antioch College, he received his Ph.D. degree from the London School of Economics, University of London, specializing in attitude research. Dr. Graham is a member of the American Association for the Advancement of Science, American Sociological Association, American Association for Public Opinion Research, and American Psychological Association and was a Fulbright Fellow in England, 1950-51.

This original article was written especially for Rehabilitation Literature.

IN ONE OF BROADWAY'S current hit musicals "a most congenial spot" for "happy ever-aftering" is "Camelot." There temperature and temperament (at least in the beginning) are under absolute control: King Arthur admits it sounds "bizarre" but "that's the way conditions are," in Camelot.

Under the spell of fantasy, I can envision a research Camelot where more research is done, basic research receives its rightful due, all research is high quality, all basic definitions are agreed to, all projects are comprehensive and long-range, financing projects is not a problem, all reports are automatically published and read, and researchers and non-researchers understand each other and go on happy ever-aftering. Before the vision blurs, let's examine this most congenial spot.

More Research

The need for more research appears to be the least controversial point of all to be raised here. A cursory glance at the literature within a 10-foot radius of one un-Camelot-like office desk reveals the unanimity of opinion from many diverse sources:

1) From a U.S. Senate document:

The case for research is so clear as to be virtually axiomatic. The unfortunate fact is, however, that research in rehabilitation, either on a national or international level, still represents only the smallest proportion of levels which experts regard as potential and/or desirable.¹ (p. 143)

2) From the proceedings of an institute on the roles of psychology and psychologists in rehabilitation:

Research, more research, and better research was one of the keynotes of the Institute. It was reaffirmed in discussions of the roles of psychologists in rehabilitation, identification with the basic science of psychology, the nature of academic education and practicum experience,

improvement in inter-professional relations, etc. It was tied to the oft-repeated belief that research on those problems faced by a person with a disability produces not only information about the disabled, but also basic psychological knowledge and theory.² (p. 79)

3) From a prize-winning doctoral dissertation on budgeting and cost behavior:

Experiments in utility maximization have used, as a basic premise, the "rationality" of man. . . . Field studies have shown conflicting results and only isolated examples of studies which indicate the possibility of introducing an adequate control scheme appear. A further weakness (from the standpoint of this study) is that almost all of the more substantial studies in this area have been directed primarily towards the behavior (motives, etc.) of production workers, as distinct from budgeting or budgeted management.³ (p. 59-60)

4) From a standard-setting seminar on rehabilitation centers for blind persons:

Research must have a part in the program of every center.⁴ (p. 10)

5) From a research conference on problems of deaf persons:

At the close of the session, lists of research problems were submitted by the conferees. A total of fifty-three suggestions were submitted. The following seven projects, listed in order of the priorities assigned to them by the conferees, represent a summary of the areas of research which the suggestions indicated.⁵ (p. 351)

6) From a government publication on rehabilitation counselors' uses of psychology:

Although the State-Federal program is so deeply immersed in a philosophy of service to its clients, the crucial need of additional research must be apparent to all.⁶ (p. 50)

7) From a review of a book on workshops:

This study raises provocative and important questions. The literature on service to the blind reveals many opinions on these subjects but few facts. Crucial research is still lacking.⁷ (p. 149)

8) From the report on research of the 1960 White House Conference on Children and Youth:⁸ (p. 10, 13, 27, 28)

Research in attitudes and practices with respect to hiring the handicapped and expanding work opportunities for the severely disabled could yield an increased supply of skilled labor and decrease the incidence of dependency and unhappiness. . . . Research and evaluation are indispensable in developing educational services for the handicapped. . . . The multi-handicapped present a unique challenge to research as the complex nature of their needs conflicts with the somewhat segmentalized character of research and service for the handicapped. . . . Improving the management of programs and institutions for the handicapped through developing methods for analyzing the cost of care and research is recommended.

9) From a joint university-government-sponsored institute:

Vocational rehabilitation offers limitless possibilities and opportunities for research and investigation. If we are

to continue our expansion program to make vocational rehabilitation available to the additional thousands of persons who need services, much more information will be required in many areas. Research and statistics has the potential to meet these needs, and Public Law 565 provides many tools which could be used to strengthen the program.⁹ (p. 86)

These statements are merely a sampling of a widespread, almost mystical feeling that the answer to any insoluble problem is research. Like Mom and apple pie, this idea in theory is held by all good citizens, even a non-Camelot.

More Basic Research

The need for basic research finds no such ready acceptance. Because it is by definition theoretical, it is understood by relatively few people (many of whom are not gifted in the art of communicating their experience and ideas in lay language). Because it is necessarily very expensive and "results" are not guaranteed, it arouses no enthusiasm among the budget-oriented. In fact, what encouragement and support basic research gets is generally from governmental agencies, a few large foundations, and a few great universities.

In the abstract, it is possible to find expressions of concern for basic research, such as the two following:

1) From testimony before a U.S. Senate committee on international medical research:

SENATOR HUMPHREY: So that basic research, which frequently suffers from lack of attention, has in the past in many areas, proved the foundation for applied research. It is at the basic research level that you really make possible ultimate advances in applied research. Is that a fair statement, Doctor?

DR. THEORELL: That's a fair statement. And it lies within the word, because you must have something to apply the research on before you can make applied research.¹⁰ (p. 263)

2) From the Director of the National Science Foundation, which is concerned mainly with basic research:

There are those who seem to feel that both money and manpower problems could be solved very simply by curtailing the support of science generally and of basic research in particular. If scientists were slowed down or prevented from coming up with so many intriguing ideas for new developments, then there would be manpower and money enough to go around. All that would be necessary would be to determine in advance what items were desirable and then to proceed with their development on the basis of exactly predetermined budgets. Nothing could be more fallacious. In the first place, the output of basic research provides the up-to-date information and data essential to modern development. This stockpile must not be reduced or the quality of our developments will suffer. Secondly, such a philosophy encourages premature development, that is, development without adequate basic research background and justification—a highly wasteful and extravagant practice. Finally, curtailing basic research means shutting the door on possible major discoveries

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or breakthroughs on which one might have capitalized in really important ways.¹¹ (p. XIV)

To the more specific, in some quarters there is a general awareness of the importance of basic research, such as is voiced in this recommendation from the 1960 White House Conference on Children and Youth: "Increased basic research is the keystone of a comprehensive program in almost every field of science and service leading to improved methods for preventing and treating mental, emotional, and physical handicaps."⁸ (p. 26)

Though it is not widely known, some basic research worth mentioning is going on of interest to the fields of hearing and visual deficits. The National Institute of Neurological Diseases and Blindness of the U.S. National Institutes of Health recently published a report of its activities and of others in the concerned basic or fundamental sciences. A sample paragraph here and there will give some idea of the scope of the Institute's interests and program:¹²

The name Institute of *Neurological Diseases and Blindness* was chosen to emphasize the objective of disease; and the scientists who direct the expenditure of funds understand the significance of the more direct as well as the basic approach, doing their best to split the invested funds wisely between basic science growth stocks which may not yield their full benefit until the next generation, and clinical science investigations which always have the chance of a rapid pay-off. Of course, many enterprises fall between.

In the subsequent report the present status of neurology and of its basic and ancillary sciences is developed. Areas in need of more intensive development are pointed out, and limited recommendations are made concerning the requirements for producing successful investigators in the future. (p. 10)

Although biophysics may seem at times far removed from the front of research on behavior, it occupies an important place at the base of the pyramid of research advance in neurology; and much work now praised might fall into the discard when advanced instrumentation finally permits us to see through the problems of behavior. (p. 32)

This list of recent advances in research in neuropathology is partial and imperfect. Many more advances, perhaps less dramatic but possibly of greater significance, have been made. Considerations of space alone do not permit mention of important research achievements even by name. (p. 54)

Briefly the present status of neurological surgery is one of extreme surgical proficiency. However, many problems remain which will require both basic science and primary neurosurgical investigation. (p. 93)

Young otologists should be trained to become "intelligent consumers" of the results of both clinical and laboratory research. Poor communication has erected unnecessary barriers between the professional laboratory investigator and the practicing otologist in spite of their common interests. The output of a few well-supported and well-staffed centers of research in otology and/or its related disciplines should improve this communication and recruit

competent young investigators who are now scarce in both otology and audiology. (p. 98)

It is apparent that there are a large number of research problems and an endless number of approaches available for the study of the blinding diseases. The most productive approaches appear to be those that correlate function, structure, and metabolism in normal and altered states. This requires collaborative efforts of clinicians with workers in neurophysiology, electron microscopy, genetics, tissue culture, immunology, biochemistry, histochemistry, etc. In addition to the funds required for such research, there is an enormous need for personnel to carry it out in a number of research centers. Efforts are being made to direct potential eye doctors into the field of academic ophthalmology. It is hoped that these individuals will be able not only to devote a considerable part of their time to research in the blinding diseases, but also will be able to accumulate about them basic research personnel as well as other research-minded ophthalmologists to form teams for the study, elucidation, cure, and prevention of the disease processes that are robbing so many Americans of their vision. (p. 104)

A much more modest activity, but every bit as meaningful to those of us interested in sensory deficits and adaptation, is going on at the Massachusetts Institute of Technology (MIT), where, with some government and some local financing and some consultation from the American Foundation for the Blind, 18 meetings have been held to date to discuss sensory research topics, involving some 325 researchers. Also a course on "sensory communications" is currently being offered. Concurrently, four research areas are being explored by staff, research assistants, and graduate students.

The first is concerned with braille, including an electric braille writer that can operate at the speed of an electric typewriter and that will incorporate standard input signals so that punched tape or cards or other storage sources can eventually be used. A photo storage system that may end in an inexpensively acquired personal library for blind persons is being investigated, and a reliable tactile transducer for a braille read-out system is receiving attention.

The second research area at MIT is concerned with mobility and guidance devices—the proprioceptive extension of the human hand and a passive analysis device that works more like the human senses than traditional guidance devices.

The third research area is that of the tactile and kinesthetic senses, concerned with the relative amounts of data obtained through the skin sensations and muscle sensing and also with a continuous tactile display that will measure the person's ability to utilize his sense of touch.

The fourth research area being explored at MIT is concerned with investigating methods other than the present multiple, miniaturized electric motor or gas approaches to help the orthopedically handicapped.

In addition to its participation in the MIT program on sensory aids, the American Foundation for the Blind has sought to interest governmental sources in furthering

necessary basic research. The following is from a number of recommendations made in December, 1960, to a Congressional committee:

Sensory Adaptation.—There is no substantial body of research information on sensory adaptation when the individual has lost one or more senses or has had one or more sensory channels reduced.

Neurophysiological, bio-physics and bionics research should be funded in a coordinated and comprehensive program to study the ways in which the blind and deaf-blind are able to secure data ordinarily provided by some other senses. Study should be made of sensory adaptation in children as well as newly blinded adults in the middle and later years of life. The role of the sensory mechanisms which tend to inhibit the information flow to the brain as well as the role of sorting processes which occurs between end organs and the brain, are two areas of special importance. In addition, some valuable information should be acquired on the length of time and the variety of training required for maximum rehabilitation. Very little is known about patterning in the central nervous system. Some relatively crude experiments have been performed in which gross electrodes have been inserted into the visual areas of the brain. These experiments have failed. There is no reason to assume, however, that at some time in the future, it may not be possible to provide at least rudimentary visual sensation. A basic research program to determine the feasibility of achieving patterning through damaged end organs at specific neural levels, or directly into the brain will provide initial clues which could lead eventually to substantial visual restoration for many blind persons. The large-scale research effort in Russia on organ transplants should be followed closely and where appropriate, additional research in the United States might lead to transplanting complete visual organs under certain conditions.

In summary, certain kinds of basic research as well as a long-range coordinated research program in the technological and biophysical areas are necessary if the country is to meet the needs of its steadily increasing blind and deaf-blind population.¹³ (p. 70-71)

More High Quality Research

In my Camelot, of course, all research design would be impeccable and rigorously adhered to, bringing not only useful new knowledge to the researcher but the delight of watching a well-thought-out plan unfold (the esthetic joy that researchers sometimes rhapsodize about).

It is fair to say that this aspect of my research Camelot glitters only over the far horizon at present. In general, many studies on blindness, for example, mix indiscriminately clients or subjects with varying degrees of residual vision, so that the sample studied may contain persons who are totally blind, have light perception only, some travel vision, or reading vision; the findings are announced as generalizations about "the blind" without reference to the very different psychosocial problems these various groups meet.

Another common shortcoming is the limited sample; a study has, say, 17 or 24 respondents and some attempt at

statistical analyses is made; cells in the table end up with few or no cases, making standard analysis impossible. Many studies, particularly theses and dissertations, are undertaken with inadequate preparation in statistical method and in preliminary searching of the literature. Too often there seems to be distrust or ignorance of the basic requirements of scientific research. These are not mystical or magic, open only to initiates sniffing the proper incense. Contrary to popular belief, those in the behavioral sciences go about their research activities in a very businesslike manner (often to the point of dullness). An example of guidelines set for research is the report of the Research Committee of the American Sociological Society, which after three years' study filed a document setting forth "specifications for sociological report rating" by which research reports could be judged.¹⁴ There are numerous other professionally approved guides to social science research that are too often ignored.

A masterful characterization of the literature on parental attitudes toward visually handicapped children is included in an as yet unpublished research report by four psychologists from the University of Rochester. They state:

It seems evident from the inventory studies reviewed in detail, as well as from those cited from skeletally, that these early attempts to investigate the adjustment and personality characteristics of the visually disabled have fallen short of their intended mark. The major causes of these failures are weaknesses in methodology and design. One serious drawback has been the use of measures standardized on nondisabled ones. Norms established for these instruments without exception fail to include persons with serious visual impairments. Another limitation is the fairly common practice of comparing residential blind school Ss with sighted Ss reared in the parental home and attending public schools. In this context Meyerson [Meyerson, Lee, *The Visually Handicapped. Rev. Educational Research*, Dec., 1953, 23:5:476-491] states:

The conditions of life for blind children living in residential schools are markedly different from the conditions which exist for seeing-children living in their own homes. The blind children are both restricted by the regulations of the institution, and protected from competition with the seeing. The meaning of their responses cannot be evaluated in terms of norms compiled for non-institutionalized seeing-children.

In such instances results may reflect differential social environment rather than the presumed personality differences stemming from differences in visual acuity.

Few of these studies report a matching of sex distribution between groups and socio-economic level of groups is virtually ignored. Although age and I.Q. are more likely to be considered, little attention is paid to grade placement which raises the question of the levels of sophistication of the groups being compared. Finally, age of onset of disability is another factor frequently overlooked or not reported in earlier studies. With these limitations in mind we must question seriously the finding by some investigators that the visually impaired are more poorly adjusted

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than their sighted peers. To be meaningful, a study purporting to investigate adjustment level or personality characteristics of a disabled group must use adequate instruments and the variables of intelligence, grade placement, sex distribution, socio-economic level, age and institutionalization should be controlled to the greatest extent possible if the visually disabled are to be compared to the sighted.

In view of the research inadequacies outlined above and the past superficial approach to the study of adjustment in the visually handicapped, it is not surprising that findings in the area deriving from an inventory-type approach have been ambiguous, contradictory, or inconclusive.¹⁵ (p. 11, 12)

It is difficult to think of anything gracious to say about theses and dissertation advisers, editors, grants councils, and others who permit poor and misleading research to see the light of day. How much more debasement the currency will stand is an open question: we are not helping the people we seek to serve by foisting off inadequate, poorly designed research reports. We should all, researchers or not, be concerned. The Rochester research group referred to concludes very much to the point:

The conclusions deriving from any research study can be no stronger than the instruments upon which they are based. We cannot overemphasize the importance of this problem to the area of research on disability in general or visual disability in particular. Research in this area is extremely young. Techniques appropriate to the peculiar and unique measurement problems inherent in it are not readily available. There is an absolutely fundamental need for the development of instruments and techniques which are appropriate to the disability group, methodologically sound, and potentially capable of providing answers to significant questions. Regrettably, investigators in the past have all too often snubbed their noses at the methodological issues which are often the bed-rock of good research. Methodological work, and the development of new instruments, is not flashy and dramatic; more often it is slow, painstaking and laborious. It does not provide ready answers in terms of content; rather it is instrumental to the provision of such answers. Hence it has come to be regarded by many as "dog-work" or "hack-work". But, insofar as the area of visual disability is concerned such basic work must be done if the field is to advance to a sounder research footing. We simply do not have the techniques and instruments available to provide a basis for answering the significant questions which must be answered. While it is eminently true that good research emanates from good ideas and significant questions, it is equally true that such research is meaningless without the requisite tools of investigation. And, in the view of the present authors, we do not have a sufficient number of requisite tools at this time in the area of the personality development and adjustment of the visually disabled.¹⁵ (p. 222)

More Meaningful Definitions

Our non-Camelot research world is not quite as bad as Alice's world where a word meant what the speaker meant it to mean, but the Wonderland characters would fully appreciate the difficulties research personnel have

with the word *blind*, for example: "the blind" includes people who are blind and people who can see—see enough at least to drive cars and to recognize friends across the street. The legally blind people who are partially sighted are not to be confused with the visually handicapped people who have great difficulty reading but who are not legally blind and certainly aren't blind.

Without belaboring an obvious point, at least in research on blindness (and I suspect among some of the other handicaps as well), we need terms that say what we mean them to say.

Let us start with "research." I offer that research is not something so uncomplicated as going to a dictionary to look up a word or counting the responses to a mail inquiry. I accept the National Science Foundation's definitions:

Research is systematic intensive study directed toward fuller knowledge of the subject studied. Research may either be basic or applied. Basic research is directed toward increase of knowledge; it is research where the primary aim of the investigator is a fuller knowledge or understanding of the subject under study rather than a practical application thereof. Applied research is directed toward practical applications of knowledge.¹⁶ (p. 4)

To proceed to my own field of specialization as an example of the need for standardized terms for research and discussion purposes, I propose: *a*) that blind means what most people think it means: without useful vision, *b*) that severely visually handicapped encompasses those now within the legal definition, *i.e.*, light perception only, enough travel vision to permit some movement-using vision, enough reading vision to permit a limited use of vision on occasions, and *c*) that visually handicapped (but outside the legal definition) be applied to those whose vision is defective but who use that vision for, principally, learning, reading, and orienting themselves.

I further submit that medical measurements are not the crucial matter concerning vision but the use of whatever vision a person has is the crucial matter. This is said well in a government publication.

It is of very great importance in the case of the partially seeing patient to determine exactly what he sees and under what conditions. This cannot be truly portrayed by ophthalmological measurement alone. Actual experience is also necessary with the patient in action. Since all visual difficulties are highly traumatic, a great deal of tact and time are required in doing this, and the individual approach to the individual patient is of very great importance.¹⁷

Even so, for research purposes classes or categories have to be set up and these classes must take into account behavioral data as well as medical data.¹⁸ Then we can explore what blindness means and does to human beings.

At least, Camelot is not entirely beyond reach on this point, since both the National Institute of Neurological Diseases and Blindness and the Subcommittee on Visual Impairments of the Association for Aid of Crippled

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Children are entertaining this disturbing thought in some of their deliberations.

More Comprehensive Research Programs

Within the last year, there have been four major studies of the needs of various handicapped groups and how research may be brought to bear on these problems. In all instances, a co-ordinated program of interdependent research projects was strongly urged. One such recommendation was made by the American Foundation for the Blind to a Congressional committee concerning basic research, discussed above. The need for a programmatic approach to the many research problems left untouched was stressed in a research conference on the needs of visually handicapped youth held by the U.S. Office of Education in November, 1960. A conference on research needs of the deaf reported as its final recommendation:

In particular, the need for programmatic research was strongly expressed by the participants in several sections of the conference. This does not represent a lack of appreciation of the importance of single studies, but rather an expression of the feelings of the conferees that many of the important research problems in deafness are of such nature and scope as to require long-term programs of research involving several disciplines. If the research needs outlined by the conference are to be met, ways must be found to interest research centers and individuals in undertaking systematic programs of research on these needs.⁵ (p. 364)

The final major conference of 1960 where research needs were clearly spelled out was the White House Conference on Children and Youth, which gave special attention to the programmatic approach:

The Need for a Comprehensive Approach to Problems— Emphasis on the total problem rather than on a portion of it or on the contribution of a specific discipline or science is fundamental to the research recommendations. This is highlighted by repeated demands for more interdisciplinary research as well as framing the problem in more natural or realistic units. This orientation to all forces affecting the problem seems to go beyond the multidisciplinary in the recognition that a unit, such as a disturbed family, interacts with a multitude of obstacles, avertures, or indifferent agents. This would preclude the tendency to divide the family among the professions. It suggests instead that the problems are pandisciplinary and that our research must accommodate to this new approach.⁶ (p. 3)

As the realization grows that the problems of rehabilitation of the handicapped are exceedingly complex, involving many disciplines and avenues of exploration, the realization may also grow that only a few well-developed research centers are equipped (or can be equipped) to undertake this work in its full scope. Individual studies are needed, isolated projects on specific problems can make their contribution, but the basic problems of the handicapped in all their complexity will never be met until massive and well-integrated programs of research are instituted at a few well-equipped centers. There is a

formidable precedent for such action. In October, 1960, The National Science Foundation recounted the history of the existing federal contract research centers, saying in part:

A major component of colleges and universities is the Federal contract research center. . . . The Federal Government's mounting concern for research and development in recent years has involved greater scope and complexity in research and development projects to meet military and civilian needs, involving heavier reliance on the research centers for resolution of problems. . . . In general, the centers may be characterized as having a flexible approach to research problems, requiring a wide variety of special facilities, often complex and costly, and the coordination of efforts of scientists and engineers from varying fields.¹⁶

Until the leadership in rehabilitation of the handicapped takes this massive, co-ordinated approach to solution of problems that now plague us, it will do little good to look to research for answers to complex and multi-faceted problems. A project here, a project there, a manual or report resulting on one aspect of some many-sided problem—that is the picture in today's non-Camelot, where frustration at not being able to get at the real problems makes one edgy and testy and paper dragons are slain instead of real ones.

More Rational Financing Procedures

The individual researcher, smarting to slay the right dragons, has a sorry time of it today. He has a hunch, a brilliant insight, somebody presses a challenging thought on him. He weighs it, turns it over, checks to see how many other people have thought of it and how well, what others think of it now. He translates it into comfortable jargon, slaps it into shape by imposing a research design on it, tames it, crows over it. Then he seeks money to consolidate his victory. First, an informal, then a formal, advisory committee on content, a financial committee or two, if he's lucky, a sounding out of the moneybags to be approached, and, if all this goes well, he has cash in hand to start, a minimum of a year from the inspiration to don armor. Most likely, as an additional duty, he has to keep the idea alive until it becomes a hair shirt. This is the process in non-Camelot.

There is an alternative. A research center (or centers) subsidized by federal funds and imaginatively administered might get the researcher to battle much earlier, while courage and conviction are in the ascendant. It is worth trying.

That this is not so visionary is apparent from the recent serious discussion in government circles about institutional grants. One recent U.S. Senate study (the chairman of the study committee of consultants, Boisfeuillet Jones, has just been named special assistant on health and medical affairs in the Department of Health, Education, and Welfare) states:

Institutional Grants. The Public Health Service should

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be permitted by law to make institutional grants, upon recommendations of the appropriate council of the National Institutes of Health, to public or nonprofit universities, hospitals, laboratories, research institutes, and other institutions, for the general support of their medical research and research training programs.

The proposed limit on such grants to 15 percent of the total research grant appropriation should be removed, and the relation of institutional grants to the total research grant program should be administratively determined. The current highly effective project grants should continue as a major method for the support of research.¹⁹ (p. 20)

Beyond the growing acceptance for the institutional grant, there is unanimous agreement among serious students of our national research effort that full costs of research must be paid obviating the present necessity to raise "matching funds" for many grants. A report of the President's Scientific Advisory Committee reads on this point:

We repeat the recommendation of an earlier report that "Government departments and agencies concerned should uniformly modify the grant and contract provisions to permit universities and non-profit research institutions to charge full cost of research performed for the government—including overhead—and to amortize capital expenditures as an allowable cost."

This recommendation has been implemented to some extent, but still requires further attention if we are not to undermine the strength of the institutions which perform the needed research. Unless research is to be cut back, the recommendation does imply increased expense, the further implementation of this recommendation should have very high priority . . .

2) The Federal Government should continue and enlarge the practice, now followed with great success in a few agencies, of providing research support over long terms and for broad objectives.²⁰ (p. 23)

Perhaps the national concern with broad objectives and long-range realistic financing of research is not such a distant development after all, but it will take persistent pressure at all levels to accomplish it very soon in the field of rehabilitation of the handicapped, where the traditional federal-state relationships (and short-term piecemeal grants) are very strong.

Better Publication Programs

In my far-off research Camelot, where all the enterprising researchers waste no time raising funds but have all assistance and equipment necessary at their beck and call, readable and useful research reports will automatically be printed and distributed to waiting readers.

The publication lag for a reasonably technical or professional report today is somewhere between 1 and 2 years. This is partially due to the irrational financing practices discussed in the section above, as the following U.S. Senate report states:

Not only is present financing of research deficient according to reports which have reached the subcommittee, but

inadequate worldwide mechanisms are available for disseminating research results which are obtained.¹ (p. 143)

The 1960 White House Conference on Children and Youth also expressed its concern in these words:

Wider Publication of Research Findings.—Support for the Children's Bureau, the Office of Education, and National Institutes of Health, and other agencies was requested so that they might "provide guidance and technical assistance to the States, printed material for parents, and coordination and dissemination of findings so as to make them available at all levels." Reports of research investigations should "be attractively and simply reported in publications for the general public so that they may implement research results by action in their own communities." These and other recommendations reflect the firm request for more, and more readable, reports of current research.⁸ (p. 5)

As stated above, one of the main reasons for publication lags is financial. Grant-making agencies are curiously reluctant to foot publication expenses, since, they argue, it might imply approval of controversial points in the report under consideration. On the other hand, researchers quite often neglect to figure on publication expenses in their project plans, for some unknown reason.

But beyond the financial problem is a more complex one of the audience for which a report is written. The report a research team writes is almost always a technical report, full of terminology and data relatively incomprehensible to laymen. Even if a good literary style is kept (and far too few keep it), the report in most cases is not suitable for program-oriented or action-oriented personnel. I suggest that this is not contradictory and that it happens in business and financial circles as well. The researcher cannot be expected to reverse his training and temperament any more than the social action personnel should. Through briefings or a second nontechnical report, the policy or social action implications can be set forth. Anyone who tries to short-cut this process is asking for trouble. The committee that gets irritated because the research team does not write the remedial legislation they recommend must remember that duPont probably did not ask its laboratory personnel who perfected nylon to market the hosiery.

As incredible as it may seem, research personnel do read one another's reports, if not with the avid interest of the daily comics, at least with a sense of duty. It is their coinage. The scientific community is indivisible: anyone who withholds or discourages publication of technical reports diminishes the effectiveness of the whole corps. More, not less, exchange of views is imperative if the complex problems we face are to be successfully tackled. That is why the publication problem must be solved.

Better Communication

Publications are not the only example of a breakdown of communications between researcher and nonresearcher.

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In fact, if the rest of my research Camelot were suddenly to be decreed and come into being, human frailty would probably do it in, as it did in the legendary Camelot and even the Broadway Camelot. In all the Camelots and non-Camelots alike there seems to be a shortage of people who can put themselves in other people's places, who can understand (and excuse on occasions) without losing their own personality or identity. To probe about a bit in some of the ways that people work, let us consider a few thoughtful expressions of points of view:

1) From the report of an institute² that became very concerned with interprofessional relationships:

How much conflict among professions is inevitable and how much is too much? Though this is a difficult question, the results of the Interprofessional Questionnaire suggest that psychologists need not be appalled at the stresses and strains of interprofessional relations. At the same time, a need for serious evaluation of the sources of difficulty was indicated. (p. 66)

Views of the sources of disturbance in interprofessional relations appeared in both the Survey of Functions and in the questionnaire circulated among the eight professions. In the Survey, which sampled the opinion of psychologists only, a frequent concern was with the poor quality of interprofessional communication. More specifically, the respondents decried the lack of effort among the professions to make their technical language understandable to members of other professions. A few respondents held that inservice training on the group dynamics of team work should be undertaken by psychologists. Several mentioned that psychologists do not adequately clarify to other professions their own possible contributions in the rehabilitation field nor do they make adequate use of other disciplines. Fully a third of the respondents stressed inadequacies in interprofessional relations as partly responsible for some of the shortcomings of psychological services. (p. 67)

2) From an interdisciplinary conference sponsored by family casework agencies:²¹

The social scientist, in consultation with the social work staff, has responsibility for translating the social work questions into research questions and for developing a research design within the limits defined by the agency. Such close collaboration may create several problems, both for the social scientist and for the agency staff. These may be in relation to communication, variance in goals and value systems, and methods of reporting. In some instances, two reports may be needed, one for use by practitioners and the other for research experts. It was noted that, in a social agency, research is a secondary, rather than a primary, function and therefore does not have the same urgency, status, or priority as the service aspects of the agency program. Careful administrative planning is therefore necessary to ensure co-operation of the service staff in a research project. (p. 123)

Our caseworkers face long waiting lists and community pressures that discourage the essential reflection and integrative effort which alone can provide essential clues. The relevant basic social science disciplines are inadequately equipped to help us. Thus, almost empty-handed, we

face the task of uncovering patterned regularities in a multivariate process of almost infinite complexity. (p. 113)

3) From a well-known sociologist speaking to social workers on kinds of "misunderstanding":²²

First, social scientists, unlike social workers, are very careful to keep their value preferences separate from their scientific theories. . . . A second source of confusion arises from the abstract sweep of the social scientist's vision as compared with the diagnostic focusing of the social worker on concrete reality in all its complexity. . . . Third, social scientists are trained to be skeptical of research results and to raise questions of reliability, and validity. . . . The social practitioner believes that any information is better than no information and is more willing to go ahead with less rigorous research designs and procedures. (p. 148)

. . . It is my firm belief that the social practitioner needs as powerful spectacles as he can get to interpret the processes of life which swirl around him. Social science research is not only producing generalizations of value but it is constantly grinding new lenses with which to peer further and more understandingly into life. The social worker must somehow obtain the benefit of these powerful instruments. (p. 171)

4) From the chairman of a social welfare workshop on research:

In our efforts to advance research as an essential discipline we must be wary not to undersell, or oversell it. In some communities it has been oversold with the consequence that the purchaser discovers that research does not deliver. On the other hand there are communities unmindful, or fearful, of the potentials of research. Because of these two opposite situations the progress of research has been impeded.²³ (p. 7)

5) From another conference of social workers:

The hope was expressed that social work research will move away from the use of case records to direct contact with the practitioner and the client, as one way of increasing the reliability of social work research.²⁴ (p. 78)

6) And from a leader in rehabilitation:

Often I am disappointed and distressed to find a more or less conscious shying away from the incursion of the university into our training programs and from the research project with its private sponsors. . . . I sense, moreover, that too many of us feel that the world outside of rehabilitation is an inexperienced world—that we will look in vain to the university and the unrelated researcher for contributions to our rehabilitation program.²⁵ (p. 5)

From these bits of evidence, it would be foolish to deny that real differences exist, differences of training, experience, and temperament. It would be equally foolish to insist that these differences mean the end of co-operation or fruitful collaboration. There are ways of dealing with such problems. One suggestion is that social perception of staff members be increased where co-operation is necessary.²⁶ Another suggestion is more pointed:

While the social scientist must assume some responsibility

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for getting appropriately placed in the work situation, it must be recognized that he does not relish being regarded as a "status seeker" any more than anyone else. Responsibility must therefore rest on the source of support to make certain that there are explicit requirements, and on the host institution for implementing these requirements as to suitable placement. In this connection one essential factor not explicitly mentioned by our respondents but implicit in many of their discussions is the presence in the situation of at least one person who is influential; is convinced of the necessity for greater utilization of social science in his profession; is well enough informed about social science to be able intelligently to represent its potentialities to his colleagues; and is willing to play the role of "patron." Indeed, it is doubtful that any of the conditions for successful collaboration here discussed could be developed except through the good offices of such a person.²⁷ (p. 12-13)

From my viewpoint as a researcher, the administrator and the fellow staff member should try to appreciate that the role of a researcher is an advisory one, not an action one; that he is, in military parlance, a staff officer, not a line officer; that he should be asked to participate regularly in policy and program decisions, not be held in reserve as some sort of service bureau to be called on when crises occur or some substantiation of a predetermined position is needed. In short, he should be what the French call *engagé* with it, in the picture, as befits his talents and sense of dedication.

The whole matter of better communication is, in the long run, a working art and the more people that work at

it the more artful it will be. It has been said more ably by a social worker:

If such research is to realize its full promise, however, a heavy investment in co-operative effort is essential. Executives, supervisors, and board members are needed who will understand its requirements and provide the necessary support and protection. Caseworkers and theoreticians must help with the formulation of penetrating questions and significant hypotheses. Progressive leaders must be willing to risk criticism to promote new patterns of observation, recording, and experimentation. Universities must furnish trained and devoted researchers and provide sound guidance in appropriate standards and methodologies. And, finally, an understanding and generous public must support not only a few selected and clearly promising projects but also the earlier, essential, but more risky, developmental stages. Only by such a pooling of effort can the field hope to witness the full flowering of research on practice, or to reap the ultimate harvest of improved insights and methods of service, the potential for which is inherent in caseworkers' privileged contacts with families.²⁸ (p. 393)

In the end, then, is it worth it to dream about this research Camelot where there is more research, more basic research, more high quality research, widely accepted standard definitions, more comprehensive programs of research, more rational financing procedures, better publication policies, and better communication between researcher and nonresearcher? The answer is the Broadway King Arthur's answer: Tell the story "strong and clear"; it may make a difference someday.

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Review of the Month

Special Education of Physically Handicapped Children In Western Europe

by

Wallace W. Taylor, Ph.D.

and

Isabelle Wagner Taylor, Ph.D.

*Published by International Society for Rehabilitation of the
Disabled, 701 First Ave., New York 17, N.Y.
1960. 497 p. tabs. \$3.50.*

Reviewed by John W. Tenny, Ed.D.

About the Authors . . .

The Taylors have extensive backgrounds in education and teacher training—social studies being the special interest of Wallace W. Taylor, while child and adolescent psychology and the psychological adjustment of the physically handicapped are the focus of his wife Isabelle. He received his master's and doctoral degrees from the State University of Iowa; she received hers from Ohio State University. Wallace Taylor is professor of education at the State University of New York, College of Education, Albany. Isabelle Taylor is chairman of the department of psychology, Russell Sage College, Troy, N.Y.

About the Reviewer . . .

Dr. Tenny was graduated from Olivet College, Olivet, Mich., and received M.S. and Ed.D. degrees from the University of Michigan. After several years as a public school teacher and principal, he joined the faculty of Wayne State University, Detroit. He is professor and general adviser, education of exceptional children, in its College of Education. He is a past-president of the Council for Exceptional Children of the National Education Association. Among societies he is a member of are the American Association of Mental Deficiency, Comparative Education Society, and the American Association of University Professors.

SPECIAL EDUCATION OF Physically Handicapped Children in Western Europe is a pioneer effort to treat in a fairly comprehensive manner the program of care and education of this group of atypical children in the numerous countries of Western Europe.* Previously written materials on the subject have been fragmentary and isolated journal articles, written relative to the program for a given type of handicapped child and usually in a particular country.

The need for such a book is stressed in the foreword by Donald Wilson, Secretary General of The International Society for Rehabilitation of the Disabled.† He reviews the interest of the United Nations, the International Labour Organization, the World Health Organization, and the World Confederation of Organizations in the Teaching Profession. Further evidence of the need was the financial support for the project from The National Foundation, the Easter Seal Research Foundation of the National Society for Crippled Children and Adults, the Association for the Aid of Crippled Children, the World Rehabilitation Fund, and the Lilly Endowment, Inc.

After careful planning and consultation, the Drs. Taylor spent 10 months in Western Europe visiting each country, reviewing documents and reports, consulting with authorities, and visiting some of the facilities for the physically handicapped. Final preparation of the report involved a year of writing and the checking of draft reports by authorities in each

*The 21 countries included in the study are: Austria, Belgium, Denmark, England and Wales, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, The Netherlands, Norway, Northern Ireland, Poland, Portugal, Scotland, Spain, Sweden, Switzerland, and Yugoslavia.

†Formerly The International Society for the Welfare of Cripples.

country. The accuracy of the report, therefore, is assured. This is of particular significance to the reviewer, who after many months is still awaiting a promised review by Soviet authorities of his article on special education in the Soviet Union.¹

The report in a sense is a twice-told tale, for Part I consists of a general survey of Western Europe as a whole, relative to organization and administration of education services, the education of the blind, deaf, and orthopedically handicapped, and vocational training and the preparation of special teachers, while Part II discusses in detail the program in each of the 21 countries.

For each country a brief background on the size, economy, and political development of the country supports in a meaningful way the history of the education of physically handicapped children. Next are brief discussions of the definitions of the handicaps in each country and the census of the handicapped to the extent this information was available. Extensive though general treatment is given to medical, social, and educational services in each country, followed by a discussion of teacher preparation and professional status. Finally, the pattern of organization and administrative services for physically handicapped children in each country is clarified.

These descriptive chapters show rather vividly the comparative influence of size of countries and agrarian as opposed to industrial societies. They also show both the retarding influences of wars on the development of programs for the physically handicapped and the constructive influence arising from postwar concern for wounded veterans and children with war-related handicaps. Some consideration is given to the influence of religious orders in the development of services. The "iron curtain" almost barred the authors, however. Yugoslavia, astride the curtain, was covered, as was Poland, somewhat more firmly behind the curtain. Evidence of Soviet influence appears in the discussion of both countries.

Residential and/or segregated day schools for handicapped children persist more strongly in Europe than in the United States. It is interesting to note that the more progressive industrial countries have had, like America, a higher incidence of blindness due to retrolental fibroplasia than more backward countries where incubators for premature infants are less available. Those concerned with the education of deaf children will be interested in the authors' view that oralism is more strongly supported in Europe than in Canada and the United States. The deaf in Europe, as in Canada and the United States, were the first of the physically handicapped to be provided with special education programs.

The book reveals considerable variation in patterns of definition of physical exceptionality and in the preparation of teachers. Definitions show ranges from none whatever to specific definitions legally prescribed. These

tend to be medical, with countries having more advanced programs tending to phrase definitions for school admittance in terms of educability. This pattern is evident also in Canada and the United States. Preparation of teachers shows a comparable variability. In some countries there is no special certification, particularly for teachers of crippled children. In others the qualification to teach mentally handicapped children carries approval to teach physically handicapped children. Persisting in some countries, more than here, are special schools having related programs of teacher preparation with a cadet teacher or on-the-job type of preparation. In other countries a department of special education in teachers' colleges is responsible for the preparation of special teachers.

In addition to those organizations and individuals involved in efforts to initiate and improve services to handicapped children in underdeveloped countries, this book will be of primary concern to those interested in comparative special education and particularly so to those planning to further their study in this field by European travel. It gives such a reader a timesaving preview of the nature of education programs for physically handicapped children, the names of agencies and of individuals concerned with the direction of the program, and also names of some of the schools and facilities that one would wish to visit. It would also have value for one making a comparative study of special education elsewhere in the world, for, as America took its guidelines from European practice in the early development of special education, so have other areas and countries of the world. This was evident to the reviewer when he visited special education programs in South America.²

The fact that Spain and Portugal, two of the less progressive countries of Europe, had the most influence on the limited development of special education in South America explains in part the nature of these services in South America. The influence of other European countries on the development of special education in Africa, Asia, Australia, and New Zealand would be comparably evident. Those who are interested in a clearer understanding of the history and development of special education in Canada and the United States will be interested in this book, since, in its discussion of the early history of special education in France, Germany, and Great Britain, the early status of special education in these countries is shown as it influenced the beginning of special education on the North American continent. It also gives a basis for the comparative study of the subsequent development of special education both here and in Europe.

The reader whose interest is primarily in the area of comparative methodology and classroom procedures will be somewhat disappointed in the book, for it gives little descriptive materials of this nature. One feels that the authors had limited backgrounds in the actual teaching of

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physically handicapped children. One must also recall, however, that the United Nations and other agencies interested in the project have need for the more general type of information provided, if these agencies are to help underdeveloped nations in the world to advance their service programs for physically handicapped children.

This book will have a value in putting the isolated articles on special education in European countries in their proper perspective. The lack of a topical index and limited subheadings will make it difficult to use the book as a ready reference. Until one has read sufficiently to get the pattern of presentation, specific information will not be easily located.

The authors indicate a number of needs for improvement of services in the various countries. The reader will wish that other investigators will have the opportunity to make comparable studies of the education of mentally handicapped, the emotionally disturbed, and the socially

maladjusted in European countries and also that investigations in depth will be made in all areas of special education to give more detail on methodology and procedures.

In the reviewer's experience, studies of special education programs in other lands do not suggest new procedures and methods that could be adopted in the countries of North America, as might be the case in less advanced countries. Such studies should help one, however, to evaluate our programs of services to handicapped children somewhat more objectively and with a less provincial viewpoint.

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Other Books Reviewed

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Anatomy and Physiology for Radiographers

By: J. E. Blewett, M.D., D.M.R., F.F.R., and A. M. Rackow, B.Sc., M.B., D.M.R.E.

1960. 322, 18 p. figs., plates. Published by Butterworth and Co., Ltd., London, and available from their U.S. office, located at 7235 Wisconsin Ave., Washington 14, D.C. \$7.50.

RECOGNIZING THE NEEDS of students in the field of radiography for more extensive background information in anatomy, physiology, pathology, and bacteriology, the authors of this book, long engaged in the training and education of radiographers, have presented in simplified form those selected parts of medical subjects the student will find useful in carrying out his work. The book provides general background medical information, comparable to that required by nurses and other ancillary professions, and follows closely the curriculum designed for those studying for the degree in England.

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Das Klapp'sche Kriechverfahren

By: Bernhard Klapp, Ella Biederbeck, and Ingeborg Hess

1961. 82 p. illus. Paperbound. Published by Georg Thieme Verlag, (14 a) Stuttgart N., Herdweg 63, Germany, and available in the U.S. and Canada from Inter-

continental Medical Book Corp., New York 16, N.Y. \$3.20.

THE FOURTH EDITION of this small book explaining the origin and practical application of a unique system of therapeutic exercises, designed by Rudolf Klapp for the correction of scoliosis and other spinal thoracic deformities, contains a discussion of the method and its uses by Dr. Klapp in treatment and prevention of such disorders. Part II(p. 29-82), by Ella Biederbeck and Ingeborg Hess, illustrates and describes technics and training aspects of the exercises, their use in treating various conditions, and equipment and games incorporating the methods.

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Play Activities for the Retarded Child

By: Bernice Wells Carlson and David R. Ginglend (illustrated by Darrell K. Sweet)

1961. 224 p. illus. Abingdon Press, 201 Eighth Ave. S., Nashville 3, Tenn. \$4.00.

THE GAMES, CRAFTS, and musical activities described in detail are designed for both normal and retarded children with a 6-year mental age or younger. Based on sound psychological and educational principles, the activities not only help to develop certain skills but bring enjoyment to the child. The introductory chapter discusses basic needs of the retarded child, objectives of recreational activities, and ways of presenting the program to the child. Activities are classified according to five areas of

development—mental health, social, physical, language, and intellectual; chapters present activities in a graded sequence, beginning with the more simple ones that the child with limited ability can perform. Suggestions are included for group projects that the whole family can enjoy. In addition to instructions for teaching an activity, the authors have interspersed specific advice on teaching methods for the retarded, explaining what may be expected at various stages of development. A brief bibliography of books and pamphlets useful to parents and teachers is included and the book is indexed.

Mrs. Carlson, the mother of a retarded child, is a well-known writer of recreation books; Mr. Ginglend, an

experienced teacher, has worked with retarded children in a variety of educational and recreational settings.

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Teaching the Educable Mentally Retarded; Practical Methods

By: Malinda Dean Garton, A.M.

1961. 233 p. illus. Charles C Thomas, Publ., 301-327 E. Lawrence Ave., Springfield, Ill. \$7.50.

WRITTEN BY A TEACHER of the educable retarded who also serves as supervisor of student teachers,

For Your Leisure-Time, Professional Reading

"I'D LIKE TO GIVE YOU THIS about Mama and Rose so you'll see how it was. Yet, if you did not have a sister like mine, will you know how pain and joy can be so closely woven that the finished texture looks much like joy? . . . Living a little for another one—that is the way we have always lived whose homes are the homes of star-crossed children. We live first a life for ourselves and then half-again a span for that frailest one. . . . Ours is a different rhythm. We long for wholeness as the broken do, yet as the broken do we see only in part. We suffer in such little ways, and in little ways we find our solace. . . . We are a curious blend, and you cannot know us truly unless you would weigh us two and two. Mama's life pivoted not on the true center of joy but on the off-center of pain, and the course it followed was not always the well-ordered one her thought decreed. . . ."

Wednesday's Child; A Tale of Love and Courage

By: Margaret Arbore Berg
1960. 197 p. Muhlenberg Press, 2900 Queen Lane, Philadelphia 29, Pa. \$3.50.

IVY HANNEMAN, ROSE'S TWIN SISTER, had much to remember from their seventh year. What she remembered may not be important to other members of the family, but it is to a seven-year old. This is the story of a family itself—besides Rose and Mama—of Papa, kind and perceptive, of Harold, the older brother, champion of the underdog, even of Grandma Hanneman and of one-year-old Jud. Rose, born with cerebral palsy, could not yet walk or talk, but, for Ivy, she had no need for real speech. They understood

one another well and had a fine time together. To Ivy, Rose was as she was. It was Mama, the perfectionist, who experienced the heartbreak of having a child who was different from all others in the German community in Minnesota where they lived, who bore the stares and comments of the unthinking and suffered the frustrations of pursuing miracles, going from doctor to food crank to faith healer. This was just before World War I, before there were clinics that provided physical therapy and speech therapy. Parents were on their own, and each member of the family had his place in the family circle.

Ivy recalls, from that year, the many little episodes that wove the four seasons together in a fabric of pain and joy, both equally acceptable and natural: the fight with neighboring children, told with earthy good humor; the visit to the doctor, when Mama first heard of Little's disease; the happy trip to the fair, where the day was spent with another family, who amazingly had a boy handicapped like Rose; the gossip of the mothers at the white elephant sale, where Mama learned much from the mother of a Negro boy paralyzed from the waist down; the long, idyllic day when Harold, Rose, and Ivy ran away from home, climaxed by Rose's first intelligible speech.

In this, her first novel, Mrs. Berg has revived the sights, sounds, smells, and rhythms of life in the "simpler" days of 50 years ago, in a home filled with growing children, including a crippled one, and where love and courage abounded. Reflecting her own experience in raising a cerebral palsied son, Mrs. Berg is also author of the very practical article "Prepare Your Child for School," which appeared in the August, 1950, issue of *The Crippled Child*. She has been an Easter Seal volunteer in one capacity or another every year since 1946.—*The Editor*

BOOK REVIEWS

this nontechnical book has much to offer both the inexperienced teacher and parent and the administrator planning to include special class programs in the regular school. Although there is no discussion of the etiology and psychology of the mentally retarded, their characteristics, objectives and organization of the curriculum, and methods for implementing learning are covered. The several extensive bibliographies contain references on more scientific aspects of mental retardation and on additional curriculum enrichment material. Unit planning is emphasized, with each area of instruction discussed separately. Much of the information would be equally useful to teachers and to parents working with children at home.

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Evaluation and Management of the Brain-Damaged Patient

By: Jerome S. Tobis, M.D., and Milton Lowenthal, M.D.

1960. 109 p. figs., tabs. Charles C Thomas, Publ., 301-327 E. Lawrence Ave., Springfield, Ill. \$6.00.

PHYSIOLOGICAL PRINCIPLES of care are emphasized in this monograph, which reflects the collective experience of the Department of Physical Medicine and Rehabilitation at New York Medical College. The rationale for the care and management of patients whose primary or secondary complaints are related to brain damage is practical and can be adapted to meet the needs of the child or adult and those with cerebral palsy, hemiplegia, parkinsonism, or multiple sclerosis. The first two chapters deal with the nature and classification of brain damage and the anatomical, physiological, psychological, and speech considerations in the treatment of such patients. The remainder of the book discusses practical application of the knowledge to the clinical technics of management. Evaluation is subdivided into sections on the neurologic, psychologic, and neuromuscular examinations. Rehabilitation technics are mainly those to improve physical and psychological functioning. An outline of technics upon which the program can be planned includes a discussion of the varied physical and psychological problems that might be encountered. The final chapter reviews the four

specific conditions mentioned above and explains how the rehabilitation principles would be applied in the management of each. A bibliography of 75 references, mainly published within the past 10 years, is an additional aid. The book is not indexed, but the table of contents, in outline form, makes for ease of reference.

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Congenital Deformities

By: Gavin C. Gordon, M.B., F.R.C.S.E.

1961. 127 p. figs. Published by E. & S. Livingstone, Ltd., Edinburgh, and available in the U.S. from The Williams & Wilkins Co., Baltimore 2, Md. \$8.50.

KNOWN FACTORS in the etiology of congenital malformations are correlated with new information derived from clinical observations of live human fetuses; particular attention was directed to the spatial environment of the fetus and to the development of lower limb movement, as well as to the anatomy and biomechanics of the human hip. Beginning with a study of the etiology of clubfoot, the author's research then progressed to study of pseudarthrosis of the tibia and to deformities of the spine and hip. A possible link between prenatal factors and environmental and genetic factors in the production of deformities was sought. The book contains detailed discussions of the clinical findings, with a wealth of case material and illustrative plates. Chapter III deals with the probable connection of congenital hip dislocation with other hip deformities. One section of the appendix considers the problems of bone growth and repair processes in bone. Conclusions regarding the early treatment of spasticity, formulated from prenatal and postnatal observations during clinical practice, have led to the development and application of principles of treatment for the intellectually impaired cerebral palsied child. The correctness of the approach, the author states, has been demonstrated by results achieved with educationally subnormal spastic children in an English school during the past 3 years. Dr. Gordon believes the available evidence indicates that the majority of cases of spasticity are developmental in origin, that spasticity is due to the inability of the forebrain, through developmental deficiency, to take over the lower evolutionary nervous mechanisms.

In Next Issue

The Article of the Month for June will be "Research in Rehabilitation of the Mentally Ill," by George W. Brooks, M.D., and William N. Deane, Ph.D. The authors are both with the Vermont State Hospital, Waterbury, Dr. Brooks as director of research and staff education and Dr. Deane as staff sociologist, and with the Vermont College of Medicine, Burlington.

Digests of the Month

Journal articles, chapters of books, research reports, and other current publications have been selected for digest in this section because of their significance and possible interest to readers in the various professional disciplines. Authors' and publishers' addresses are given when available for the convenience of the reader should he desire to obtain the complete article or publication. The editor will be most receptive to suggestions as to new publications warranting this special attention in Digests of the Month.

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Rehabilitation Nursing Record

By: Georgina Greene, M.S.N. (*Nursing Instructor, Benjamin Rose Hospital, Cleveland Ohio*), and Lavina Robins, B.S. (*University of Minnesota Hospital, Minneapolis, Minn.*)

In: *Am. J. Nursing*. Mar., 1961. 61:3:82-85.

NURSES AND PATIENTS alike complain of service by nurses being less personal, less satisfying than that of many years ago. Patient-centered care is a constant subject of nurses. In the Benjamin Rose Hospital, a geriatric hospital, an unusual record developed by the nurses helps us apply the principles of this type of care.

Patients average over 70 years of age and a 38-day stay. They seldom enter with one simple medical problem. About 47 percent have had a recently immobilized fractured hip or a recent cerebrovascular accident. The goal for each patient is to maintain independence within his limitations, the minimum being self-care. The patient's social problems are as important as his physical and emotional rehabilitation.

Especially in a rehabilitation hospital, routines can be deadly unless staff and patients share knowledge and feelings. The older patient particularly needs the security of routines, day-to-day continuity of purpose, and a uniform staff attitude. He needs to be respected without being pushed past his limit of endurance and needs to feel responsible for his own self. Most of all, he needs to feel surrounded by workers with a feeling of hopeful progress toward some goal. Persons in many disciplines must work together so he is not "taken apart." Doctor, social worker, therapist, and nurse are all involved in changes in his daily routines.

The nursing record at our hospital is part of a complex communications system that achieves our aims, filling several needs:

- A nursing record form that can be completed with little or no duplication of effort, with a minimum of writing and of personal value judgments and a maximum of objectivity—one that can be understood by nonprofessional staff members.
- A written definition of immediate goals that are realistic and specific for each patient, to guide work of all personnel.

- An objective tool for evaluating and reporting the patient's status and progress in a quantitative way.
- A means of promoting continuity of care between tours of duty and between nurses, so that the patient can get the kind of care he would if one person were continuously taking care of him.

Hospital divisions have two large Kardexes, each holding a 5 by 8 inch visible index card for each patient, plus an 8½ by 11 inch nursing record for each patient. On both are recorded almost every kind of information that may be needed. The smaller card is at the top and lists all current medications and treatment. A temporary check-off slip over its right side is replaced every 24 hours. The nurse checks off and signs for medications poured and given, so she need not chart them. A secretary does the charting, totaling the daily dosage of drugs actually received by the patient and entering it on the graphic sheet of the patient's chart.

A similar system records treatments and laboratory work. The nurse's charting time can be spent productively for the patient, clarifying her knowledge of his progress and producing a useful record for patient care and research.

This special record form is a 2-column, 8½ by 11 inch card, printed on good-grade paper that will stand use. The left-hand column (the functional level chart) lists 10 activities of daily living (ADL), in the order found most useful for nurses on all tours. Status grades are listed after each activity with spaces for inserting check marks. A section is marked "leg brace." Other aids are listed under "ambulation." Status of activity grades are: zero or nonfunctioning, assist, observe, or independent. Meanings are literal, but there is a list of definitions. New nursing service employees are oriented as to the chart. In the ADL section lists can be checked in the "TEACH INDEPENDENCE" or "DO FOR" category, depending on goals set for the patient and his limitations. Nurses make notes in the right-hand column, which remains in view in the Kardex until the record form is transferred to the patient's chart, at the end of the first 3 days in hospital and at the end of each 7 days thereafter. When removed from the Kardex, nursing record forms are replaced with fresh. The head nurse or one assigned to the patient records in the right column any data not covered in the left.

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The nurse should record objectively, facts not judgments. If judgments are recorded, facts from which they were drawn must be given, so others may make interpretations.

In the right-hand column, the nurse writes of the patient's adjustment to the hospital, socialization with other patients, moods, habits affecting his living schedule in hospital, likes and dislikes, reactions to family visits, worries, and other things of interest. Any first time for an activity checked in the left-hand column must also be recorded here.

The left side is furnished the division as a separate half-page, placed over the full sheet in the Kardex as a working sheet. Check marks thus can be changed from day to day, as capabilities change. Lead pencil checks are used for waking hours of the day and red for normal sleeping hours. Nurses report any changes at the end of each tour and the charge nurse changes the check marks. At the end of the first 3 days and then each 7 days, check marks are transcribed permanently to the whole sheet, which is taken from the Kardex and made a page in the patient's permanent folder. At this time the nurse writes in the right-hand column a summary of the period's achievement by the patient.

The ward secretary uses a system of dating to make sure the summaries are written at the right time. She lists summaries due on the division calendar, checking them off as recorded by tour nurses. The night nurse completes the summaries and removes the record from the Kardex. The secretary inserts it in the chart the next morning and a new form into the Kardex for the day nurse's recording. An alert, systematic secretary aids greatly in maintaining the system.

The record telescopes time and makes progress discernible, because it is recorded at weekly intervals. The nurse is aided in working with other disciplines. The head nurse takes the Kardex to biweekly rounds, attended by the medical director, house officers, physical and occupational therapists, and social workers. There each patient is discussed thoroughly and new goals set. She also takes the record to weekly orthopedic rounds, during which the patient goes through prescribed activities in the physical therapy room and members of the different professions discuss the next steps. Changes noted at rounds are recorded.

At this hospital certain risks are taken so that the patient may learn by doing, and there are times when the patient's safety is not assured. He is safer, however, in an environment where every worker knows exactly what has been taught and accomplished yesterday. One of the hardest things for new staff members to acquire is the ability to allow the patient to do for himself—to interest and to encourage him and to bolster him when progress is slow. The borderline between helping and forcing to do

is shadowy. The similarity of elderly patients and the very young may complicate—the patient may make a contest of situations and draw the nurse into trying to win by getting activities checked off, while the patient forgets his aims. The record should not become a score sheet.

The professional nurse must help the staff retain perspective. The staff also must always be looking for new uses for such a good tool as the nursing record. Properly used, it can help the patient feel that though he is not "taken care of" he is indeed "cared for."

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Childhood Behavior Disorders: Subtler Organic Factors

By: Don P. Morris, M.D. (3511 Hall St., Dallas 19, Tex.), and Elizabeth Dozier, M.A.

In: *Texas State J. Med.* Mar., 1961. 57:3:134-138.

ALTHOUGH ORGANIC CAUSES of behavior deviations have often been acknowledged in children with more severe brain damage or mental retardation, such factors are less often suspected or found in children of normal or superior intelligence and in those of superficially normal appearance with no gross neurologic or orthopedic defects.

A group of 8 boys and 4 girls of from dull normal to superior intelligence were found to have organically determined behavior disorders. Age ranged from 4 years, 9 months to 14 years, 3 months, the median being 8 years. Behavioral features most often noted in the history were hyperactivity, hypermotility, destructiveness, overaggressiveness, and cruelty or sadism. The subtlety of handicap led to misunderstanding by parents, teachers, and physicians. Most parents thought the behavior psychologically determined or caused by child-rearing practices. Most referrals were by physicians, but only two or three of the children were suspected to have an etiology involving organic factors.

In many cases parents were aware of the child's unhappiness, social difficulties, and school problems. Close questioning usually reveals driven behavior present since birth or early childhood with unusual consistency and persistence—in contrast to more emotionally determined disorders, in which symptoms often start later, fluctuate, and are variable. In organically determined cases, the child is apt to behave in the office or elsewhere much

as described by the parents. In those of emotional cause, children who are "holy terrors" elsewhere are frequently quiet and co-operative at the office, especially at the first visit. In lesser degrees of organicity, the child has a history of good first impressions, followed by a rapid "wearing out" process with the same timing in varied situations. With emotional disturbances, the state of relationships between the child and others in a situation fluctuates.

A constant symptom in organic etiology is the child's being restless and also continuously sleepless at night for the first year or two. Occasionally noted symptoms may imply disease of the nervous system: recurring episodes of low-grade fever (found in 2), transient convulsions at or near birth (2), obesity in infancy (2), and polydipsia and polyuria (1).

Underlying medical causes are hard to determine. In the series there was a history of German measles in the first trimester of pregnancy (1), fairly prolonged anoxia in early infancy (1), prolonged unexplained high fever (105° to 106° F.) at age $2\frac{1}{2}$ (1), and possibly difficult or traumatic birth (2).

This type of hyperactive-aggressive behavior has special features. When not conscious of being watched, the child may be very rough in handling things. He may be hyperactive and aggressive on awakening or in a new relationship with a child, before conflicts or difficulties have had a chance to develop. Some of the activity thus appears relatively impersonal. Slight impediments in speech noted by parents and examiners were described as indistinctness, changes in pitch, slurring, muttering, stuttering, or stammering.

Testing

Physical and neurologic examinations showed scattered findings: internal strabismus (2), port wine stain on forehead (1), unusual fat distribution (2), small genitals (1), stubby hands and fingers (1), unilateral Babinski signs (2), and gait disturbance (3 or 4). Difficulty in fine co-ordination of hands, almost consistently found, plays a subtle but important role in many of the child's problems.

We usually observe children in the waiting room or play room, then follow with whatever formal examination is possible. How the child performs a maneuver requested is important; he may succeed in a finger-to-nose test, but with movements that are tense, agonizing, slow, and seemingly overcompensatory. In block design, he may correctly arrange the blocks but be awkward and may rotate them out of the normal position. In play therapy, handling of cards or materials can be observed.

The group ranged in full scale intelligence quotients from 85 to 141, with a median IQ of 111 and an average IQ of 112. In the Wechsler Intelligence Scale for Chil-

dren, the subtests most frequently falling below the mean level of ability of a child were arithmetic and digit span in the verbal scale, and block design, object assembly, and coding in the performance scale. The most frequent combination of low scores in subtests was in arithmetic, digit span, and block design; others were in arithmetic and digit span with either object assembly or coding.

The block design subtest involves eye-hand co-ordination, perception, memory, and spatial concept analysis and may reveal clumsiness with materials, inability to reproduce the simplest designs, trouble in arranging blocks in a square, rotation of square designs to a 45-degree angle, and reversed design. Visual organization may be demonstrated as affected. Help given in this kind of test is of relatively less benefit in the more organically determined cases than in the more emotionally determined problems.

In organic dysfunctions, quality of drawing both in the Bender-Gestalt design and in drawings of persons is below that expected of the intellectual level. The designs frequently show maturation lags, unevenness of development in different designs, regressive tendencies such as substitution and perseveration, and at times fragmentation, rotation, and reversals. Drawings of persons are static, stilted, rigid, and stereotyped. Finger paintings almost regularly show impulsivity and low quality.

Electroencephalographic abnormalities included generalized convulsive patterns of grand and petit mal types (2), bursts of 2-4 sec. delta and saw-tooth delta waves (4), and delta bursts combined with 5-6 sec. theta activity and 18/sec. beta activity (1). In one case slow wave bursts were nearly confined to the posterior. There were no significant lateralized patterns.

Wether abnormalities suggested are permanent is by no means clear. Follow-up examinations are of obvious importance. We believe some of the most disturbing behavior in these children comes from stimuli within the nervous system and the brain per se. Interpretation and management, however, does not rest on organic consideration or methods alone. Emotional difficulties also arise from the neuroses and needs of the parents or the dynamic balance of the individual family structure. Children have special emotional problems secondary to the handicap. They have feelings of inferiority in comparisons with other children's accomplishments. The reason behind inferior performance is often unrecognized by teachers, friends, and family. Urging may result in further tension, frustration, and sometimes disappointment and bitterness with continued failure at tasks. A child may react to misunderstanding with aggravated, truly aggressive retaliation.

Therapy

Drugs, especially tranquilizers, are important in the treatment of these patients, as they are effective in modify-

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ing behavior. The resulting greatly increased acceptance of such a child at home, at school, and elsewhere can be a good start toward reversing the otherwise vicious cycle of rejection and retaliation and can prepare the way for psychological, social, and educational means of further help.

Anticonvulsant drugs are less effective, although in a 5-year-old girl given 4 grains of phenobarbital daily, activity was slowed to a moderate degree. We have obtained greater results with Thorazine, in doses of 75 to 125 mg. daily. Others use other tranquilizers with good results, as do many with Benzedrine or Dexedrine. Overactive behavior returns when the drug is withdrawn. Some of our patients have received medication for 3 or 4 years.

Detailed interpretation and explanation of the diagnosis is influential in treatment. Parents need to understand the special implications of this handicap for the activities of their child. Emotional problems in accepting the diagnosis must be dealt with. Data should be interpreted for the teacher in relation to specific subjects that are taught so she may see where help can be given and where limitations should be accepted. Physicians have been too shy and hesitant about explaining the handicap to the child himself, who may be guessing or wondering about his disability.

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Today and Tomorrow in State Programs

By: Charles R. Gardipee, M.D. (*Chief, Bureau of Crippled Children's Services, California State Department of Health, 2151 Berkeley Way, Berkeley 4, Calif.*)

In: *Workshop Conference: Emotional Problems of Handicapped Children and Young Adults, held at San Francisco State College, July 21, 22, 1960, with the cooperation of United Cerebral Palsy Association*, p. 19-21. (1961?) 67 p. Mimeo. Issued by the Department of Special Education and Rehabilitation Counseling, San Francisco State College, San Francisco 27, Calif.

I WOULD LIKE TO GIVE YOU the philosophy I think has developed in California toward a balance between public and voluntary or private services in meeting some of the needs of handicapped children and their families. In California we have a myriad of services—special schools built with state funds, special teachers and special education, transportation allowances to get the children to these special schools, increased monies for their teaching, residential schools for those with special handi-

caps, and therapists provided in schools for treating children with orthopedic handicaps. All these are available to the general public without regard to income or other standards of eligibility. There is also medical care available for most handicapped children requiring special education, special institutions for retarded children, and a special program for the older disabled child. We have programs for placing disabled children in foster homes; we have vocational counseling available for children over 16 years of age. All these are state-sponsored with public funds. We also have private agencies sponsoring such things as nursery schools and day care centers and recreational activities, paying for medical care in certain instances, providing home physical and occupational therapy for the homebound handicapped child, sponsoring research, and sponsoring facilities such as rehabilitation centers. One agency even runs a hospital for children, with parent counseling among other activities.

In general the philosophy seems to have developed that those services that are continuing, are costly, and serve a well-established need are to be met at state expense. Voluntary agencies provide the monies for new services, those the state cannot perform for some reason, or those that are exploratory or in the research area.

The future of state programs depends on future needs. The pattern in California in general is that the state will provide financial assistance with its programs to be administered at county level. The state sets standards for the expenditure of funds. Programs, as I see it, will continue to be maintained at their high level. California's Crippled Children's Services, providing medical care for those in need, is the largest program in the United States. In the immediate future is a program developed in the last year—pilot day care centers for severely handicapped children who cannot attend school and are not eligible for day care centers open to the normal child. These centers will be available without regard to the financial means of the family, except that families able to pay the full cost will be asked to do so. A child will be left on an intermittent basis—full time or for only one or two days a week. This program now depends on a few school districts interested in setting up pilot centers. The centers will fill an important need: a chance for the mother of a severely handicapped or severely retarded child to carry on normal activities without watching the child around the clock.

Many services are available, and the eligibility requirements and ways to get services are varied. Every agency has its own "magic words." With the right words your child will be accepted—if you use the wrong words, you must go back until you find someone to tell you the right words. This is one of the major problems in obtaining services from state and voluntary agencies, resulting in a great deal of parental confusion. The current Gov-

ernor's Committee on Medical Aid and Health is evolving the "one-door principle." It concerns the question, "How do we get services to people to minimize the number of contacts they have to make with different individuals representing different agencies?" For the next 10 years we should work hard to see if we can't provide services with a minimum of contacts with various agencies and with everyone informed as to the proper words. It will entail co-ordination of effort among state agencies because of duplication and it will require new technics in handling personal and counseling types of services.

During the next 10 years I hope we can afford parents more counseling time. Children are getting the best medical care available in this state, but physicians, social workers, and others skilled in counseling must help with problems around the handicapped child. The family, under tremendous strain economically and emotionally, often breaks up. The parents and family are the greatest resource of the child and, when the family goes out of the picture, problems develop. One only has to go into one large county in this state and count the number of handicapped children abandoned in the county hospital to realize that families are unable to meet all the emotional problems involved. Crises situations arise—when the child

enters school, when the child starts falling behind in school, or when vocational planning begins. Other family crises affect the care of the handicapped child.

Vocational rehabilitation services now provide counseling to children aged 16 and older. Many need this counseling earlier. Treatment, especially in the orthopedically handicapped, must be directed toward an occupational goal earlier than this. Vocational counseling in the schools must also be strengthened. The rehabilitation workshop movement must be built up. Special legislation now enables a school district to purchase workshop services from existing workshops in an area. There are not enough good workshops available to all school districts to implement this law. Better institutional care must be developed for the older handicapped child who cannot be employed and is not eligible for one of our institutions for the retarded. A few such children are now in the wards of county hospitals or the chronic nursing homes of counties. This group needs services; we must realize that a certain percent will not be employable and will not be able to live at home because parents have died or are not available.

Other needs and services will develop. It will be up to the public to decide how it wishes to spend its tax money and what needs it wishes to meet at public expense.

(Continued from page 138)

- and Benham, Frank G., *Adjustment to visual disability in adolescence*. 1961. 351 p. (To be published)
16. National Science Foundation, *Reviews of data on research and development. 23. Federal contract research centers in colleges and universities, fiscal year 1958*. Washington, D.C.: The Foundation, Oct., 1960. 4 p.
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 21. Research relevant to casework treatment of children, p. 105-123, in a report of the Conference on Family Casework in the Interest of Children, Chicago, October, 1957. *Soc. Casework*. Feb.-Mar., 1958. 39:2-3.
 22. Angell, Robert C., A research basis for welfare practice. *Soc. Work J.* Oct., 1954. 35:4:145-148, 169-171.
 23. Storandt, Kenneth M., Opportunities for research in community welfare, in: United Community Funds and Councils of America and the National Social Welfare Assembly, *Proceedings of 11th Annual Adirondack Workshop, July 1-6, 1960*.
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 26. Richardson, Stephen A., Psychological problems in rehabilitation. *J. Rehab.* Sept.-Oct., 1960. 26:5:20-22.
 27. Russell Sage Foundation, *Annual report, 1959-1960*. New York: The Foundation, 1960. 89 p.
 28. Beck, Dorothy Fahs, Potential approaches to research in the family service field. *Soc. Casework*. July, 1959. 40:7:385-393.

Abstracts of Current Literature

This abstracting section, together with other numbered references indexed in this issue, serves as a supplement to the reference book Rehabilitation Literature 1950-1955, compiled by Graham and Mullen and published in 1956 by the Blakiston Division of McGraw-Hill Book Company, New York. An author index will be found on the last page of the issue.

ACCIDENTS—PREVENTION

323. Willenberg, Ernest P. (*Dept. of Special Education, Los Angeles City Schools, Los Angeles, Calif.*)

A conceptual structure for safety education of the handicapped. *Exceptional Children*. Feb., 1961. 27:6: 302-306.

The first of a series of articles prepared by a joint committee of the National Safety Council and the Council for Exceptional Children, it attempts to establish that handicapped children do face unique hazards and that there is a relationship between the classification of the impairment and the type of hazard facing such children. Factors in the internal and external environment must be altered so that the child may live in comparative safety and without fear. It is the task of the school to provide adaptations in the school program that will help handicapped children acquire habits of living that minimize accidental risks.

ADOLESCENCE

324. Abel, Georgie Lee (*San Francisco State College, San Francisco 27, Calif.*)

The blind adolescent and his needs. *Exceptional Children*. Feb., 1961. 27:6:309-310, 325-327, 329, 331-332, 334.

Basic needs of blind adolescents as they relate to the needs of all people, their special needs caused by lack of sight, and what the blind adolescent and his family expect of the community and of professional persons working with the blind are covered in this paper given at a symposium on "A Comprehensive Developmental Program for Blind Children," presented at the 1960 International Convention of the Council for Exceptional Children. Suggested areas for continued research are considered.

APHASIA

325. Ingram, T. T. S. (*Dept. of Child Life and Health, Univ. of Edinburgh, Edinburgh, Scot.*)

Paediatric aspects of specific developmental dysphasia, dyslexia and dysgraphia. *Cerebral Palsy Bul.* 1960. 2:4: 254-277.

The three conditions all represent disturbances in the development of particular language functions; they are closely related and in many respects show similarity in etiology and clinical findings. The author reviews the literature concerning each condition in regard to differential diagnosis, etiology, associated clinical features, and psychiatric symptoms. The importance of psychological testing in the diagnosis of each syndrome is emphasized. In spite of the close association claimed for these dis-

orders, there is still a tendency to regard them as separate entities, rather than different manifestations of disordered speech and language development. The rational treatment of dyslalia, idioglossia, or dyslexia requires a knowledge of the functional nature of the disorders.

See also 345.

ART

326. Boardman, Eunice (*Univ. of Wichita, Wichita 14, Kan.*)

The art and music program at the Institute of Logopedics, Wichita, Kansas, by Eunice Boardman (and others). *Cerebral Palsy Rev.* Jan.-Feb., 1961. 22:1:8-9, 11.

At the Institute art and music serve a specific communicative developmental function, a concept differing from the traditional therapeutic approach directed mainly toward psychotherapeutic goals. The administration of the two programs and the philosophy upon which this particular use of music and art is based are discussed. Emphasis of the programs is on the communicative process involved, rather than on the artistic results achieved.

ARTHRITIS—PHYSICAL THERAPY

327. Rogers, Jean B. D. (*Robert Jones and Agnes Hunt Orthopaedic Hosp., Oswestry, Eng.*)

Rehabilitation following surgery for chronic arthritis. *Physiotherapy*. Feb., 1961. 47:2:39-40.

An outline of a physical therapy treatment plan, specifically applied to the arthritic patient who undergoes surgery of the hip joint. Treatment in the preoperative and postoperative periods and when the patient becomes ambulatory is described; common complications, in the order of their frequency, are listed. Follow-up treatment in the home or clinic, following hospital discharge, is stressed. For a general discussion of rehabilitation services following surgery for chronic arthritis, based on principles of the Piercy Committee report, see *Rehab. Lit.*, Apr., 1961, #258.

BACKACHE

See 348.

BLIND

See p. 130; 324; 395.

BLIND—PSYCHOLOGICAL TESTS

328. Davis, Carl J. (*Perkins School for the Blind, Watertown 72, Mass.*)

A comparison of the oral and written methods of administering achievement tests, by Carl J. Davis and Carson

ABSTRACTS

Y. Nolan. *Internat. J. Educ. of the Blind.* Mar., 1961. 10:3:80-82.

Results of a pilot study of the administration of Stanford Achievement Test subtests in both oral and braille forms indicate a need for further studies to adjust scoring technics and time limits for the braille form. The use of normative data for the seeing to provide final grade equivalent scores for the blind is questioned.

BRAILLE

329. American Foundation for the Blind

Broadening professional horizons; selected readings in social welfare and related fields currently available in braille or recorded form; introduction by Alexander F. Handel. New York, The Foundation, 1961. 21 p.

Approximately 250 books, some classics and others published within the past few years, are listed; subject fields covered include social work, psychology, psychiatry, anthropology, economics, and administration, with the majority in the first three categories. Very brief annotations identify subject matter in those entries where title is not self-explanatory. An availability code indicates where and in what form the books are available. Blind students, blind professional personnel, librarians serving the blind, and families of blind persons would find the list most useful in encouraging wider reading in related fields.

Available from American Foundation for the Blind, 15 W. 16th St., New York 11, N.Y.

330. Hanley, Leo F. (*College Reading Center, Boston Univ., Boston, Mass.*)

A brief review of the research on braille reading. *Internat. J. Educ. of the Blind.* Mar., 1961. 10:3:65-70.

Since braille will continue to be the principal medium of instruction in formal education of the blind, a review of the current status of research in problems of blind readers is not encouraging. Four subjects that relate to the study of touch reading, and the literature available in each area, are discussed; composition of braille, the mechanics of touch reading, instructional methods, and tests of braille reading achievement are covered. Suggestions for future research in areas warranting immediate attention are given.

BRAIN INJURIES

331. Nelson, C. Donald (*3181 S.W. Sam Jackson Park Rd., Portland 1, Ore.*)

Subtle brain damage; its influence on learning and language. *Elementary School J.* Mar., 1961. 61:6:317-321.

Mild brain damage in children often produces subtle and less obvious behavioral traits and may be the cause of severe learning difficulties in the areas of reading, language, writing, or arithmetic. Some of the disorders described briefly are sequence difficulties, familial language disabilities, confused cerebral dominance, perseveration, writing and spelling disturbances, poor sound discrimination, and difficulty in abstraction. Dr. Nelson stresses the need for evaluation of such children by trained specialists; the teacher is an essential member of the evaluation team.

The author, a speech clinician and research assistant at the University of Oregon Medical School, has, for the past two and a half years, been a member of a team of specialists engaged in evaluating language disorders.

See also 318; 384.

BRAIN INJURIES—DIAGNOSIS

332. Hanvik, Leo J. (*300 Queen Ave. N., Minneapolis 5, Minn.*)

Diagnosis of cerebral dysfunction in child, as made in a child guidance clinic, by Leo J. Hanvik (and others). *Am. J. Diseases of Children.* Mar., 1961. 101:3:364-375.

A report of an interdisciplinary research study to determine the extent of diagnostic agreement between the pediatrician, the neurologist, and the clinical psychologist in evaluating brain damage in children. Routine encephalographic, pediatric, and clinical psychological examinations were given all children, ages 7 through 14, referred to Washburn Memorial Clinic, a children's psychiatric outpatient facility in Minneapolis. After screening, 108 children were selected as subjects of this research project. Analysis of the results of testing are discussed; in the sample of children studied, diagnosis of brain damage varied widely among the various diagnostic tools. A multidisciplinary approach, with one clinician, preferably a physician, assuming responsibility for the final diagnosis is preferred in all cases of children in whom cerebral dysfunction is suspected.

See also 321; 340; 382.

BRAIN INJURIES—PSYCHOLOGICAL TESTS

333. Fitzhugh, Kathleen B. (*100 Van Nuys Rd., Newcastle, Ind.*)

Psychological deficits in relation to acuteness of brain dysfunction, by Kathleen B. Fitzhugh, Loren C. Fitzhugh, and Ralph M. Reitan. *J. Consulting Psych.* Feb., 1961. 25:1:61-66.

Findings from a study of psychological impairment in 3 groups of brain-damaged patients and a control group, each consisting of 16 patients, the mean age of each group around 33 years, suggest that acuteness of organic brain lesions is an important variable to be considered in the study of psychological deficits in the brain-damaged. All patients were administered the Wechsler-Bellevue Intelligence Scale, Form I, and seven of the Halstead indicators (referred to in the bibliography accompanying the article). Methods and results of the study are described. The control group's performance was found to exceed consistently the performance of the brain-damaged. Two static lesion groups (one institutionalized) also rather consistently performed at levels superior to those of the acute lesion group.

CEREBRAL PALSY

334. Spastics' Quart. Mar., 1961. 10:1.

Contents: The place of neurosurgery in cerebral palsy, John Hankinson. p. 3-8.—Clumsy children, John N. Walton. p. 9-21.—School leavers, adolescents, and adults, D. M. Peaps. p. 22-27.

In this group of papers presented at a 1960 conference

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held in England, Dr. Hankinson, a neurosurgeon (*Royal Victoria Infirmary, Newcastle upon Tyne*) discusses two operative procedures—cerebral hemispherectomy and stereotaxic operations on the basal ganglia—and their place in treatment of cerebral palsied children. Case histories of seven children with apraxic and agnosic defects, treated at Percy Hedley School (*Newcastle upon Tyne*), are discussed by Dr. Walton, a neurologist (*Royal Victoria Infirmary*). Accurate assessment and evaluation of mental and motor ability cannot be made in a single examination, he believes; patient training can bring improvement in many such children. Miss Peaps (*Percy Hedley School*) told of the club, classroom, workshop, and recreational activities provided school leavers, adolescents, and adults through the facilities of the school. Problems of this particular group of the cerebral palsied were also discussed in the articles published in the September, 1960, issue of *Spastics' Quarterly* (see *Rehab. Lit.*, Nov., 1960, #807).

CEREBRAL PALSY—DIAGNOSIS

335. Dittrich, J. (*Charles IV Univ., Prague, Czech.*)

Pneumoencephalographic findings in various forms of cerebral palsy, by J. Dittrich, J. Jirout, and V. Vlach. *Cerebral Palsy Bul.* 1960. 2:4:286-289.

Theoretical and practical value of the use of pneumoencephalography in the diagnosis of cerebral palsy is discussed. When clinical findings of 117 encephalograms were studied, the four types of classification—diplegia, hemiplegia, hypotonia, and extrapyramidal forms—were found to be insufficient. Subjects of the study were patients treated in the Children's Department of the Neurological Clinic of Charles IV University, Prague; the majority were between the ages of 4 and 7. The method is useful in differential diagnosis and provides more precise information where surgical intervention is being considered.

CEREBRAL PALSY—MEDICAL TREATMENT

336. Saturen, Phoebe (*New York Med. College, 106th St. and Fifth Ave., New York, N.Y.*)

Evaluation and management of motor disturbance in brain-damaged children, by Phoebe Saturen and Jerome S. Tobis. *J. Am. Med. Assn.* Feb. 18, 1961. 175:7:588-591.

Because brain damage in prenatal or early neonatal life can result in disabilities varying from mild to total mental and physical incapacity, diagnosis should begin with appraisal of the newborn. Periodic examinations are necessary and will help in determining a differential diagnosis when brain damage is suspected. Specific abnormalities may not be seen, however, until the second year or later. A simple home therapy program can be started in early infancy and can help to prevent deformity. With the beginning of voluntary motor activity, more formal therapy can be planned. Various approaches to treatment are reviewed briefly and the type of therapy used in the Department of Physical Medicine and Rehabilitation, New York Medical College, is explained. The changing nature of the rehabilitation program, as the child grows, is pointed out. Continuity of care should be provided by the family physician or pediatrician, using community resources and consultation with specialists as the needs arise.

337. Stamm, T. T. (*Guy's Hospital, London, Eng.*)

Disabilities of the foot in cerebral palsy. *Cerebral Palsy Bul.* 1960. 2:4:238-243.

In same issue: Hip deformities in cerebral palsy, J. S. Batchelor. p. 244-247.—Knee deformities in cerebral palsy, G. A. Pollock. p. 248-253.

Main indications for surgery and the operative technics used in the correction of muscle imbalance and deformity are discussed. In considering possible procedures that may be required for the feet, the whole problem of improving the patient's mobility and independence should be studied in the light of any future operations that may be necessary. So far as the foot is concerned, lengthening the tendons for contracted muscles produces better results than neurectomy; the correction of muscle imbalance is more satisfactorily achieved by arthrodesis of the affected joints than by muscle transplants.

Dr. Batchelor (*Guy's Hospital, London*) discusses two procedures for correction of spastic deformity of the hip that are, in his opinion, the most useful. Rotation osteotomy of the femoral shaft and the Lorenz osteotomy correct the deformity below the insertion of the spastic hip muscles, which are left undisturbed. A careful preliminary assessment of the patient's mental status, power of balance, and co-ordination is essential, as well as evaluation of the function of the upper limbs and hands.

Dr. Pollock (*Princess Margaret Rose Hosp., Edinburgh*) emphasizes the need for surgical intervention when conservative measures have failed to correct severe forms of knee-flexion deformity in the patient with cerebral palsy. In the more severe forms of the deformity, extensive surgery and a long period of immobilization in plaster are required, followed by postoperative therapy and long-term follow-up. Surgical procedures are discussed.

See also 318; 319; 374; 378.

CEREBRAL PALSY—PHYSICAL THERAPY

338. Karlsson, B. (*Kronprincessan Lovisas Barnsjukhus, Stockholm, Swed.*)

Results of physical treatment in cerebral palsy, by B. Karlsson, B. Nauman, and L. Gardeström. *Cerebral Palsy Bul.* 1960. 2:4:278-285.

Using a combination of methods described by Dr. Karel Bobath and Mrs. Irene Collis, well-known British authorities, physical therapists administered treatment to 114 children over a 3-year period. Bandaging and prostheses were rarely used and no orthopedic surgery was performed during the period of observation. Findings stress the importance of early treatment; intensive treatment seemed particularly valuable for children with spastic hemiplegia or paraparesis, less so for those with athetosis and ataxia. Improvement was noted in 60% of the 89 adequately treated patients and in 36% of the 25 treated inadequately. Among patients with severe motor handicaps, severe mental retardation, or epilepsy, improvement was minimal.

CEREBRAL PALSY—SURVEYS—MINNESOTA

339. Wallace, Helen M. (*U.S. Children's Bur., Washington 25, D.C.*)

Cerebral palsy in Minnesota; method of study, prev-

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alence, and distribution, Part I, by Helen M. Wallace (and others). *Am. J. Public Health*. Mar., 1961. 51:3: 417-426.

A report of the first phase of a state-wide survey in Minnesota during 1958-1959, discussing statistical procedures and findings. The prevalence rate of 1.3 per 1,000 of total population in Minnesota does not differ markedly from rates reported in the Schenectady study. Under-reporting of patients accounts for the corrected estimate of 1.4 per 1,000 of total population.

CHILDREN'S HOSPITALS—ADMINISTRATION

340. Marie Loretta, Sister (*Child Evaluation Clinic, 148 E. 67th St., New York, N.Y.*)

Child evaluation clinic. *Hosp. Progress*. Feb., 1961. 42:2 (Pt. 1):59-63.

The Child Evaluation Clinic, an outpatient division of St. Vincent's Hospital, New York City, is the outgrowth of a program for mentally retarded children. Physical, psychological, and psychiatric services are given children through diagnosis, evaluation, and placement. Parent and teacher education are also an integral part of services, and a research program is contemplated. The author believes the Clinic has proved its worth, despite the expense it entails, in discovering children whose apparent or pseudomental retardation has been eventually diagnosed as a physical defect or emotional disturbance. Illustrated. (See also *Rehab. Lit.*, Dec., 1960, #918.)

CLEFT PALATE—SOUTH AFRICA

341. Marks, Margaret (*Univ. of Witwatersrand, Johannesburg, S. Af.*)

A team-work approach to cleft palate rehabilitation in South Africa. *J. S. African Logopedic Soc.* Dec., 1960. 7:1:8-10.

Lack of professional specialists, the facilities to train additional personnel, and the time to conduct research are special problems in considering a team approach to cleft palate rehabilitation in South Africa. Suggestions for the possible composition of a cleft palate team, its functions, and adaptations that might have to be made in applying the plan to conditions in South Africa are offered. Miss Marks bases her discussion on observations made at Northwestern University's Cleft Lip and Palate Institute, its administration, and purposes.

CONGENITAL DEFECT

342. Apgar, Virginia (*Research Dept., The National Foundation, 800 Second Ave., New York 17, N.Y.*)

Human congenital anomalies; present status of knowledge. *Am. J. Diseases of Children*. Feb., 1961. 101:2: 249-254.

Various factors contributing to congenital abnormalities are reviewed. Genetic aspects, radiation hazards, chemical agents thought to produce abnormalities, infectious disease in the pregnant mother, and environmental and social factors are all suspect. Preventive measures to eliminate or correct congenital anomalies are being considered by governmental and private agencies.

343. Ebert, James D. (*6728 Glenkirk Rd., Baltimore 2, Md.*)

First International Conference on Congenital Malformations; summary and evaluation. *J. Chronic Diseases*. Feb., 1961. 13:2:91-132.

A summary of the information on congenital malformations, their frequency and origin, and research findings to date, from 29 papers presented at the First International Conference, held in July, 1960. Complete text of the papers will appear in the official proceedings, to be published by J. B. Lippincott Co., Philadelphia.

See also 319; 381.

CONGENITAL DEFECT—ETIOLOGY

344. Davids, Anthony (*Psych. Dept., Brown Univ., Providence, R.I.*)

Anxiety, pregnancy, and childbirth abnormalities, by Anthony Davids, Spencer DeVault, and Max Talmadge. *J. Consulting Psych.* Feb., 1961. 25:1:74-77.

A report of an ancillary study to the National Collaborative Project, which is investigating perinatal factors in child development. The study, mainly testing further the clinical validity of the Manifest Anxiety Scale, compared measures of manifest anxiety obtained during pregnancy and following childbirth and related the findings to experience of normal or complicated delivery. Significantly higher manifest scores were obtained from women who were later to experience complications at delivery or were to give birth to children with abnormalities. The implications of the study suggest the use of projective methods for further research to determine the role of emotional factors in pregnancy and childbirth. In the authors' opinion, findings demonstrate the clinical utility of the MAS.

DEAF—DIAGNOSIS

345. Rosenblüt, Benjamin (*Jewish Hospital of St. Louis, St. Louis, Mo.*)

Vestibular responses of some deaf and aphasic children, by Benjamin Rosenblüt, Robert Goldstein, and William M. Landau. *Annals Otol., Rhinol., and Laryngol.* Sept., 1960. 69:3:747-755.

In same issue: Neurologic observations on a population of deaf and aphasic children, by Robert Goldstein, William M. Landau, and Frank R. Kleffner. p. 756-767.

Among 164 children of the Central Institute for the Deaf, St. Louis, there was a greater proportion of abnormal responses among aphasic than among deaf children. The findings indicated, however, that vestibular tests have negligible value in the differential diagnosis of auditory disorders in young children; normal responses do not rule out deafness. The absence of depression of responses could be related to severe labyrinthine or peripheral neural impairment or to presumed lesions of the central nervous system, as in aphasic children. Vestibular responsiveness seemed more clearly related to etiologic factors than to any other factor in the group studied.

The second article reports findings of a comprehensive neurological study of 188 children at the same school; 32% of the aphasic children were found to have no additional abnormalities in any of the neurological studies performed. Minor physical findings and dysrhythmic EEGs

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were no more common among the aphasic than among the deaf. However, the "neurologically normal" aphasic children could not be distinguished from the remainder of the aphasic group in auditory and speech behavior and educational progress.

DEAF—STATISTICS

346. Connor, Leo E. (*904 Lexington Ave., New York 21, N.Y.*)

Determining the prevalence of hearing impaired children. *Exceptional Children*. Feb., 1961. 27:6:337-339, 341-344.

A representative sampling of the results of studies and surveys of children's hearing impairments in the U.S. during the past three decades reveals wide variation in estimates. A national study of the hearing levels of pre-school and school-age children should be undertaken to improve treatment and preventive programs. Co-operative study among professionals in the hearing field could result in standardization of testing conditions, equipment, terminology, and reporting.

DRUG THERAPY

347. LaVeck, Gerald D. (*Rainier State School, Buckley, Wash.*)

The use of psychopharmacologic agents in retarded children with behavior disorders, by Gerald D. LaVeck and Phyllis Buckley. *J. Chronic Diseases*. Feb., 1961. 13:2:174-183.

A summary of findings of studies evaluating a number of tranquilizing agents used at the Rainier State School over the past two years. Drugs tested were fluphenazine, a combination of meprobamate and promazine, deanol, mephenoxyalone, and chlordiazepoxide. Results of these studies are not as encouraging as others that have appeared in the literature. There was suggestive evidence that a combination of meprobamate and promazine modified behavior disorders so that the child could be more easily managed in the institution but side effects of lethargy and drowsiness may have been responsible. On fluphenazine 10 of 24 children improved as compared to 5 of 24 who received a placebo. With this drug there were no signs of toxicity.

348. Winokur, S. (*4729 Prytania St., New Orleans 15, La.*)

Evaluation of a new muscle relaxant in the practice of physical medicine. *J. La. State Med. Soc.* Mar., 1961. 113:3:83-89.

Of 62 patients treated with Soma, in conjunction with the usual physical therapeutic measures, 42% experienced excellent results, 22% very good results, 9.6% good, and 4.8% fair results. In only 8% of the group was the drug ineffective. In the author's experience, Soma has proved at least as effective a muscle relaxant as any other drug available but does not produce the usual undesirable side effects. In general, Soma showed best results in acute low-back syndromes arising suddenly following some unusual activity; in these cases pain and muscle spasm disappeared rapidly.

EPILEPSY—EMPLOYMENT

349. Shafter, Albert J. (*Southern Illinois Univ. Rehabilitation Institute, Carbondale, Ill.*)

Planning vocational objectives with epileptics, by Albert J. Shafter and George N. Wright. *J. Rehab.* Mar.-Apr., 1961. 27:2:11-12.

The authors outline a set of criteria to be used as a guide for rehabilitation counselors. The counselor must first assess the functional aspects of the client's epilepsy; next he evaluates the nature of the occupation. The relationships between the two factors must be considered in the choice of occupations. A case history illustrates the calculated risks the counselor must often face in placing the client.

EXERCISE

350. Clarke, David H. (*Dept. of Physical Education, Univ. of California, Berkeley, Calif.*)

Progressive resistance exercise in adapted and corrective therapy. *J. Assn. Phys. and Mental Rehab.* Jan.-Feb., 1961. 15:1:12-15.

Research findings on exercise and exercise physiology are examined in an effort to formulate concepts for the treatment of hospitalized patients. Discussed are static and dynamic exercise and the objective determination of resistance load for given muscle groups. Further investigation of the many facets of exercise is needed to determine cause and effect relationships.

See also 380.

HARD OF HEARING

351. Menzel, Otto J. (*8441 S.W. 16th Terrace, Miami, Fla.*)

Some aspects of hearing rehabilitation. *Eye, Ear, Nose and Throat Month.* Mar., 1961. 40:3:208-209.

Rehabilitation of persons with permanent auditory handicaps calls for team effort; the otologist should be responsible for the co-ordination of services and follow-up. The majority of patients can be served adequately by direct referral to the hearing aid dealer; those with anticipated fitting problems should be referred to an audiology clinic if one is available. Criteria to aid in anticipating fitting problems are discussed briefly. It is the otologist's duty to be familiar with currently available hearing aids and community facilities for rehabilitation.

HARD OF HEARING—PSYCHOLOGICAL TESTS

352. Horlick, Reuben S. (*Dept. of Corrections, Reformatory Div., Government of District of Columbia, Lorton, Va.*)

A comparative personality study of a group of stutterers and hard of hearing patients, by Reuben S. Horlick and Maurice H. Miller. *J. Gen. Psych.* Oct., 1960. 63:259-266.

A report of a preliminary study of the adjustment problems of 26 stutterers and 26 hard of hearing patients referred for speech therapy; all were enlisted male military personnel. The California Test of Personality was used to determine characteristics of each group, how dependable

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the differences were, the extent to which stutterers and hard of hearing persons differed from a standardization group, and whether there was a characteristic basic personality structure for each group. Clinical observations and findings of the authors are not in agreement with those of previous investigators who attributed characteristic personality traits to the hard of hearing. No one characteristic pattern of adjustment for either group could be identified in this study. The literature is briefly reviewed.

HARD OF HEARING—SPECIAL EDUCATION

353. Streng, Alice

Children with impaired hearing. Washington, D.C., Council for Exceptional Children, 1960. 72 p. figs., tabs. (CEC Special Publ., Administration of special education in small school systems)

Another of the Council's series of booklets planned to aid the administrator, teacher, or professional worker employed in schools of small communities or rural areas. Miss Streng, professor of education for exceptional children, University of Wisconsin (Milwaukee), describes elements of a good hearing program, ways to enlist community support, methods for identifying children with hearing impairments, and types of educational adjustments possible for children of varying ages and amounts of hearing loss. Good supervisory practices and administrative responsibilities in special education programs are defined and illustrated by examples of programs representing different organizational patterns. A brief list of selected references, sample forms suggested for a conservation of hearing program, minimum requirements for clinical certification of speech and hearing therapists, as set up by the American Speech and Hearing Association, standards of training for teachers of the deaf, and a list of organizations interested in the hearing impaired are given in the appendix. The bulletin is indexed.

Available from Council for Exceptional Children, 1201 16th St., N.W., Washington 6, D.C., at \$2.00 a copy.

HEART DISEASE (CONGENITAL)—NURSING CARE

354. Craig, Evelyn S. (*Indiana Univ. Med. Center Hospitals, Indianapolis, Ind.*)

Nursing care of the child after open heart surgery, by Evelyn S. Craig and Sarah Pack. *Am. J. Nursing.* Feb., 1961. 61:2:78-80.

Unusual anxiety and tension in parents, and in the child himself, are somewhat lessened by prehospitalization visits. The authors, both experienced in recovery room duty, tell in some detail what such care entails. A list of the materials and equipment used in the recovery room is appended.

HEMIPLEGIA

355. Adams, G. F. (*Wakehurst House, Belfast City Hosp., Belfast, Ire.*)

Prognosis and survival in the aftermath of hemiplegia, by G. F. Adams and J. D. Merrett. *Brit. Med. J.* Feb. 4, 1961. 5222:309-314.

A detailed analysis of prognosis and survival in a series of 736 patients with hemiplegia of vascular origin, accepted for rehabilitation 2 weeks or more following onset of their strokes. It was found that age alone did not preclude good recovery nor did a lesion of the dominant hemisphere. The earlier physical retraining was begun, the better the chance for functional recovery. Factors influencing prognosis and survival in this series of patients are discussed.

HOME ECONOMICS

356. Connecticut. University. School of Home Economics

Child care equipment for physically handicapped mothers; suggestions for selection and adaptation, prepared by Neva R. Waggoner and Garland W. Reedy. Storrs, Conn., The School (1961). 36 p. illus.

One of a series of studies on child care problems of more than 100 orthopedically handicapped mothers of preschool children, it describes results of testing commercial and adapted equipment to determine its usefulness. Criteria in the selection of equipment are outlined; it is stressed, however, that no one piece of equipment is particularly suited to a specific disability. Beds, bathing equipment, play pens and toys, feeding and toileting equipment, clothing storage and dressing centers, and work centers for child care are covered. The bulletin is based on studies in "Work Simplification in the Area of Child Care for Physically Handicapped Women," made by the School of Home Economics, University of Connecticut, over a period of years (see *Rehab. Lit.*, Oct., 1957, #1187).

Available from Handicapped Homemaker Research Center, School of Home Economics, University of Connecticut, Storrs, Conn. Price list on request.

HOMEBOUND—NEW JERSEY

357. Yaguda, Asher (*61 Lincoln Park, Newark 2, N.J.*)

Homemaker service; the scope and the hope. *Conn. Health Bul.* Mar., 1961. 75:3:87-92.

In same issue: A look across the nation, Lucille M. Smith. p. 93-97.

Dr. Yaguda, consultant and honorary chairman of the Committee on Community Homemaker Services, New Jersey State Department of Health, describes the origin of the state's homemaker services in 1950 in the largest urban county. Today 16 agencies in 14 counties make such services available to three-quarters of the state's population. A university training course for homemakers, the co-operation of other state departments, local committees of the state volunteer group, and local sponsoring agencies have combined to make the program a highly successful one.

Mrs. Smith, Chief, Health Services Organization Branch, U.S. Public Health Service, offers some statistics on the growth of the homemaker services movement on the national level. Also described are methods used by individual communities in planning new programs, how support is solicited, and the value of financing from multiple sources. The responsibility of the family physician in determining individual need for such services is stressed.

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LARYNGECTOMY

358. Arnold, Godfrey E. (*61 Irving Place, New York 3, N.Y.*)

Alleviation of alaryngeal aphonia with the modern artificial larynx: I. Evolution of artificial speech aids and their value for rehabilitation. *Logos*. Oct., 1960. 3:2: 55-67.

In same issue: The new Western Electric No. 5 Type artificial larynx, Harold L. Barney. p. 68-72.

A review of the development, over the last century, of the five types of artificial speaking devices: the externally applied reed larynx, internal replacement of the larynx by mechanical devices simulating all laryngeal functions, cervical application of the electrolarynx, direct activation of the oral resonator by an external electrolarynx, and intraoral sound source. There is still demand for prosthetic devices among persons who, for varied geographic, economic, and physical reasons, cannot learn esophageal speech. Advantages and limitations of artificial speech aids are discussed. 102 references.

Mr. Barney, a research engineer (*Bell Telephone Laboratories, Murray Hill, N.J.*) discusses engineering principles of an experimental electronic artificial larynx and the acoustic performance of the device. Intelligibility of speech is appreciably better with the electronic device than with the mechanical reed type. Reactions of the few who have used the new artificial larynx are overwhelmingly favorable.

359. Reed, George F. (*Salada Bldg., Berkeley and Stuart Sts., Boston, Mass.*)

The long-term follow-up care of laryngectomized patients. *J. Am. Med. Assn.* Mar. 18, 1961. 175:11: 980-985.

Long-term management often is the responsibility of physicians not specifically trained in the care of such patients; problems of a psychological, medical, and social nature are discussed. Care of the tracheostoma, use of the laryngectomy tube, management of the inadequate stoma, the question of subsequent anesthesia, and the detection of recurrences and metastases should be thoroughly understood by the physician. The patient should be counseled on the inadvisability of swimming or boating, on the loss of sensations of taste and smell, on personal hygiene, and on the various means of developing a substitute voice following operation.

MENTAL DEFECTIVES—CONNECTICUT

360. Meyers, Stanley (*Off. of Mental Retardation, Conn. State Dept. of Health, 165 Capitol Ave., Hartford 15, Conn.*)

Meeting Connecticut's needs for the mentally retarded. *Conn. Health Bul.* Feb., 1961. 75:2:39-43.

Connecticut State Department of Health's Office of Mental Retardation, created by legislation in 1959, began operation in February, 1960. Mr. Meyers, director of the Community Services Division, summarizes activities of the Office during its first year of operation. Various conferences and seminars for public education and parent guidance were held, diagnostic clinic and day care services have been created and extended with grant-in-aid funds voted by the legislature, and new programs to provide additional day care centers, vocational training, and re-

search in preventive aspects of mental retardation have been initiated. Proposals for ways of providing additional much needed services will be submitted to the legislature.

MENTAL DEFECTIVES—PROGRAMS

361. Gibson, Robert (*Manitoba School for Mental Defective Persons, P.O. Box 1190, Portage la Prairie, Man., Can.*)

Trends in the rehabilitation of institutional mental defectives. *Canad. Med. Assn. J.* Nov. 12, 1960. 83: 1046-1049.

With the expansion of community facilities for the education of higher grade mental defectives, the over-all trend apparent in institutional admissions is toward acceptance of younger, more severely retarded children, destined for long-term care. Such a situation will increasingly reduce turnover in institutional populations, creating a definite shortage of beds available. Rehabilitation of both high-grade and low-grade defectives becomes a necessity. With the high-grade, traditional placement in suitable employment, directly or through some type of sheltered living, following vocational and social training, is possible. Methods suggested for rehabilitating the low-grade defective include the use of special hostels and sheltered workshops, transfer to institutional day care centers, or placement in foster homes.

See also 340.

MENTAL DEFECTIVES—PSYCHOLOGICAL TESTS

362. Bolduc, Thomas E. (*Psychiatric Services, Wales, Wis.*)

Social value-need patterns in mental retardates. *J. Consult. Psych.* Dec., 1960. 24:6:472-479.

To isolate and identify common patterns of solutions to social value-need conflict situations, a scale consisting of 95 items was used with two groups of mental defectives, drawn from the population of an institution and from special education classes of public schools. Each item of the test was constructed so that the subjects were required to make a forced-choice response to a familiar, social conflict situation. Design of the scale and some implications of the factors involved are discussed. The possibilities of using this or other similar instruments to differentiate institutionalized and noninstitutionalized mental retardates were considered.

363. Luria, A. R. (*Research Section, Institute of Defectology, Moscow, U.S.S.R.*)

An objective approach to the study of the abnormal child. *Am. J. Orthopsychiatry*. Jan., 1961. 31:1:1-16.

Traditional and present day medical and psychological approaches to the abnormal development of children in Russia and to the problems of differential diagnosis in children failing in school are discussed by the well-known Soviet psychologist. Diagnostic methods used to determine whether the child does not hear, does not listen, or does not understand are explained. This address was presented at a special session of the American Orthopsychiatric Association in 1960. A brief discussion of the address was made by Dr. Arthur L. Benton, Dept. of Psychology, State University of Iowa.

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MENTAL DEFECTIVES—RECREATION

See 316.

MENTAL DEFECTIVES—SPECIAL EDUCATION

364. Erdman, Robert L.

Educable retarded children in elementary schools. Washington, D.C., Council for Exceptional Children, 1961. 60 p. figs., tab. (CEC Special Publ., Administration of special education in small school systems)

Both organizational principles and practical suggestions for initiating and implementing the special class program for educable mentally retarded children in schools of small or medium-sized communities are discussed in this bulletin intended for use by school administrators, teachers, and interested parents. Discussed are selection and screening of children, determination of location and size of the class, qualifications of the teacher selected, work with parents, the core curriculum, and planning daily and weekly schedules of instruction. Additional aids are the sample referral and history-recording forms, a list of agencies working in the field of mental retardation, selected references for parents, teachers, and administrators, and a list of suggested equipment and supplies. Description of three successful special class programs, each representing a different organizational pattern to meet specific needs of a particular geographic location, show how such classes are integrated with the regular school.

Available from Council for Exceptional Children, 1201 16th St., N.W., Washington 6, D.C., at \$1.75 a copy.

See also 317; 381.

MENTAL DISEASE—EMPLOYMENT

365. Salzberg, Theodore (2377 Midvale Ave., Los Angeles 64, Calif.)

Employer attitudes toward hiring the emotionally handicapped, by Theodore Salzberg (and others). *J. Rehab.* Mar.-Apr., 1961. 27:2:18-19.

A survey of 78 small firms in Los Angeles revealed that the majority believed, in theory, at least, that the handicapped person should have equal opportunity for employment. Follow-up records indicated, however, that only 13% actually hired patients from the neuropsychiatric hospital of the VA Center. Re-education of prospective employers has not proved productive and state and local resources for retraining the handicapped are reluctant to accept the emotionally disabled. Facilities established to meet the specific needs of such clients might result in more encouraging rehabilitation achievements.

MENTAL DISEASE—PROGRAMS

366. Freeman, H. L. (Littlemore Hosp., Oxford, Eng.)

The day hospital. *World Mental Health.* Nov., 1960. 12:4:192-198.

The evolution of the day hospital in Great Britain has greatly increased the range of treatment that can be offered for psychiatric illness. Distinct advantages in the treatment setting, ability to maintain contact with the family during the treatment process, ability to provide services to larger numbers of persons without large capital investments for new buildings, and availability of com-

munity resources to aid in treatment support the argument that the day hospital program fulfills needs on a rational basis.

MONGOLISM

367. Kugel, Robert B. (Newton Rd., Iowa City, Iowa)

A comparison of mongoloid children, by Robert B. Kugel and David Reque. *J. Am. Med. Assn.* Mar. 18, 1961. 175:11:959-961.

Subsequent development of 21 institutionalized mongoloid children and 34 mongoloids reared at home was studied. Motor and speech skills were acquired earlier by children kept at home; family adjustment was considered good in 55% of such homes. Regardless of diagnosis, children should remain in their own homes at least until age 5, to insure their optimal development. Family factors should be considered carefully before institutionalization is recommended. Data for the study was obtained in part from records of the Department of Pediatrics, State University of Iowa College of Medicine, and of the Woodward State Hospital and School. A questionnaire survey of parents yielded further information.

MUSCLES

368. Harrison, Virginia F. (Brooke Army Med. Center, Ft. Sam Houston, Tex.)

A review of skeletal muscle. *Phys. Therapy Rev.* Jan., 1961. 41:1:17-24.

In same issue: A review of sensory receptors in skeletal muscles with special emphasis on the muscle spindle. p. 25-29.—A review of the motor unit. p. 30-40. (Both by same author)

The three articles report findings of a research study of the anatomy and physiology of skeletal muscles, variations in structure, activity of the neuromuscular mechanism in three processes—excitation, conduction, and response, the function of muscle spindles, and a review of the literature dealing with anatomy and action potential of the motor unit. Bibliographies of the three articles contain a total of 175 references.

MUSCLES—TESTS

369. Smith, Laura K. (Dept. of Rehabilitation, Baylor Univ. Coll. of Medicine, Houston, Tex.)

Muscle testing: Part 1. Description of a numerical index for clinical research, by Laura K. Smith (and others). *Phys. Therapy Rev.* Feb., 1961. 41:2:99-105.

The manual muscle test, useful in research situations, has proved impractical when large numbers of patients are studied in routine clinical practice. This paper describes a manual muscle test form used at the Texas Institute for Rehabilitation and Research; it employs a numerical index for estimating the total involvement. The total muscle number does give a representation of the departure of muscle strength from tests norms and can be used to show changes in muscle strength status. Valid use of the test requires extensive judgment and knowledge of its limitations. A study of examiner reliability will be discussed in the second part of the article, to appear in a later issue of *Phys. Therapy Rev.* The muscle test form was devised by Dr. Paul R. Harrington in 1950

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and has been in daily clinical use at the Southwestern Poliomyelitis Respiratory Center since 1953 and retained in use at the Texas Institute for Rehabilitation and Research.

NERVE INJURIES

370. Hickok, Robert J. (*Div. of Rehabilitation, Jewish Hosp. of St. Louis, 216 S. Kingshighway Blvd., St. Louis 10, Mo.*)

Physical therapy as related to peripheral nerve lesions. *Phys. Therapy Rev.* Feb., 1961. 41:2:113-117.

Diagnostic procedures include manual muscle testing, routine electrical tests, testing for strength-duration curve, chronaxy determinations, and electromyography. Therapy is aimed at retention of joint mobility, the prevention of deformity, reduction of edema (when present), and the retention of denervated muscle in an adequate nutritional state. An exercise program, beyond the use of simple passive motion, is prescribed on an individual basis, depending on the type of lesion and the degree of recovery anticipated.

NURSING—RECORDS

See 320.

OLD AGE—MEDICAL TREATMENT

371. Dacso, Michael M. (*1082 Park Ave., New York 28, N.Y.*)

Maintenance of functional capacity. *J. Am. Med. Assn.* Feb. 18, 1961. 175:7:592-594.

Practical application of simple procedures can greatly prevent or reduce the number and severity of crippling conditions. Effective measures for maintenance of functional ability in such conditions as contractures, osteoporosis, and disuse atrophy are discussed. Community resources should be utilized in maintaining the physical and intellectual function of the elderly and chronically ill.

372. Friedfeld, Louis (*121 E. 60th St., New York 22, N.Y.*)

Geriatrics, medicine, and rehabilitation. *J. Am. Med. Assn.* Feb. 18, 1961. 175:7:595-598.

Describes the administration, services, and results obtained in a geriatric clinic established in 1954 in a general hospital (*Beth Israel Hospital, New York City*). It offers a comprehensive diagnostic and treatment program of health care and rehabilitation to help the elderly live effectively within their own community. Analysis of the first 100 patients served shows the wide variety of problems encountered and the range of services needed. After 2 years of treatment 65% of the patients showed improvement in medical, psychiatric, or psychosocial areas and 33% in all areas. By helping to maintain patients in their own homes, long-term care is less costly.

OLD AGE—PROGRAMS

373. White House Conference on Aging

Recommendations of the Rehabilitation Section. . . . *J. Rehab.* Mar.-Apr., 1961. 27:2:13-14.

Under the chairmanship of Dr. Howard A. Rusk, director of the Institute of Physical Medicine and Rehabilitation, New York City, working groups of the Rehabilita-

tion Section at the January, 1961, White House Conference on Aging considered deficiencies in rehabilitation services for the chronically ill and disabled. It was generally agreed that rehabilitation is a co-operative responsibility of local, state, and federal resources. Recommendations urge increased vocational and medical services, supporting services in the community to meet social and economic problems of aged and chronically ill persons, and more comprehensive program planning. The establishment of a National Institute of Rehabilitation should be considered as a means of strengthening rehabilitation efforts.

ORTHOPEDICS

374. Bul., Tulane University Medical Faculty. Nov., 1960. 20:1.

Partial contents: Geriatric orthopaedics, Griffin Bland, p. 11-15.—Rehabilitation of lower extremity amputees, E. T. Haslam (and others), p. 23-28.—Flexion deformities of the knees in cerebral palsied children, H. R. Soboloff, p. 29-32.—The orthopaedic surgeon takes a closer look at congenital paraplegia, Bennett H. Young, p. 33-35.—The cause and treatment of spastic flat feet, George D. B. Berkett, p. 37-39.

The *Bulletin* is published quarterly by the Faculty of the School of Medicine, Tulane University, 1430 Tulane Ave., New Orleans 12, La.

PARAPLEGIA—EQUIPMENT

375. Nyquist, Roy H. (*Spinal Cord Injury Service, VA Hosp., Long Beach, Calif.*)

Standing bars, by Roy H. Nyquist (and others). *J. Assn. Phys. and Mental Rehab.* Jan.-Feb., 1961. 15:1:3-5.

Illustrates and describes two new standing devices developed at the Long Beach VA Hospital. A review of experience at the treatment center from 1946 to 1960 shows how various devices were developed from the original modified Stokes litter basket. Latest standing bars are either portable or fixed.

PARAPLEGIA—MEDICAL TREATMENT

376. Smolik, Edmund A. (*Doctors Bldg., 100 N. Euclid, St. Louis 8, Mo.*)

Spinal cordectomy in the management of spastic paraplegia, by Edmund A. Smolik, Francis P. Nash, and Otakar Macheck. *Am. Surgeon.* Oct., 1960. 26:10:639-645.

Results of dorsolumbar spinal cordectomy used in the treatment of two patients with traumatic spastic quadriplegia and two patients with spastic paraplegia are reported. The procedure abolished mass flexor spasms in all of the patients, facilitating rehabilitation. Patients were eventually advanced to wheel chair life and discharged home. Their psychological improvement was as striking as the physiological alterations in muscle tone. The muscular, metabolic, autonomic, and visceral responses to the procedure are discussed.

See also 399.

PARAPLEGIA—PSYCHOLOGICAL TESTS

377. Wachs, Hirsch (*Northwestern Univ. Med. School, 303 E. Chicago Ave., Chicago 11, Ill.*)

Studies of body image in men with spinal cord injury,

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by Hirsch Wachs and Misha S. Zaks. *J. Nerv. and Mental Dis.* Aug., 1960. 130:8:121-127.

Self-concepts of 30 male patients were evaluated through analysis of results of a Draw-a-Person test. All patients had disturbances of bowel, bladder, sexual, and lower extremity functions. When compared with a control group of chronically ill, long-term hospitalized male veterans who were ambulatory and had no disturbance of function, the patients with spinal cord injury showed a tendency toward more anxiety and tension, with a greater dependence on their environment, especially on the female figure in this environment. However, in most respects, there was no significant difference between groups in respect to "body image," as determined by the test. The failure to find pronounced differences may reflect the general degree of disturbance in psychological functioning of any chronically ill patient.

PHYSICAL EFFICIENCY

378. Hellebrandt, F. A. (*Motor Learning Research Laboratory, Univ. of Wisconsin Medical School, Madison, Wis.*)

The influence of athetoid cerebral palsy on the execution of sport skills: bowling; a study of one case, by F. A. Hellebrandt, Joan C. Waterland, and C. Etta Walters. *Phys. Therapy Rev.* Feb., 1961. 41:2:106-113.

Results of cinematographic and electromyographic analysis of the bowling throw as executed by an adult female with moderately severe quadriplegic athetoid cerebral palsy are reported and compared with performance of a normal control subject. The cerebral palsied subject was systematically trained to throw the bowling ball from a comfortable sitting position. Findings suggest that such a patient can acquire ability to throw a bowling ball; no involuntary motions distort the movement pattern of the throwing arm. Exercise stress evoked attitudinal reflexes that appeared to facilitate performance. Similarities in neuromuscular patterning of the normal and the cerebral palsied subjects were more conspicuous than abnormalities of behavior. The Motor Research Laboratory is a co-operative project of the Easter Seal Research Foundation and the University of Wisconsin Graduate School.

PHYSICAL MEDICINE

379. Martin, Gordon M. (*Mayo Clinic, Rochester, Minn.*)

Clinical applications of physical medicine and rehabilitation to general medical problems. *Proc., Staff Meetings Mayo Clinic.* Feb. 15, 1961. 36:4:75-87 (*Current practices in general medicine.* 20.)

Noting that lay enthusiasms and pressures for rehabilitation services have developed faster than physicians' abilities to organize and provide essential services, Dr. Martin believes the patient's own physician can treat and rehabilitate those with neuromuscular and skeletal problems encountered in general medical practice. Applications of physical medicine to such conditions as backache, stiff and painful shoulder, cervical syndromes, rheumatoid arthritis, degenerative joint disease, hemiplegia, parkinsonism, demyelinating diseases, asthma, and emphysema are discussed.

380. Redford, John B. (*Univ. of Washington School of Medicine, Seattle 5, Wash.*)

Physical medicine, III: Principles of therapeutic exercise. *Northwest Med.* Aug., 1960. 59:1022-1025.

In same journal: Physical medicine, IV: Massage and electric stimulation, John B. Redford. Sept., 1960. 59: 1142-1147.

The physiologic effects of exercise, its clinical applications, and types of exercises are discussed briefly. Although programs for specific disorders are not described, the author does include a list of exercises of value for instructing patients.

Indications and contraindications for the use of massage and electrical stimulation and the technics and precautions to be observed are discussed in Part IV of this series of articles by Dr. Redford on the modalities of physical medicine.

Other articles in the series appeared in the June, 1960, issue of *Northwest Medicine* (Part I: see *Rehab. Lit.*, Feb., 1961, #147); Parts II and V, on principles of thermotherapy and on teaching patients to walk, appeared in the July and October, 1960, issues respectively.

PREMATURE BIRTH

381. Drillien, Cecil Mary (17 Hatton Place, Edinburgh 9, Scot.)

The incidence of mental and physical handicaps in school-age children of very low birth weights. *Pediatrics.* Mar., 1961. 27:3:452-464.

Data on the later development of 49 children, born in two Edinburgh hospitals between 1948 and 1956, are presented. All were premature, weighing 3 pounds or less at birth. Incidence of physical defect affecting education, behavior problems, results of intelligence tests, and educational attainments are discussed. One half of the total sample were found to be ineducable in normal schools for reason of physical or mental handicaps or both; one quarter were dull children requiring special educational treatment in the normal school; and one quarter were considered low average, average, or superior in ability. Data are compared with similar studies made in the U.S. and a follow-up study conducted in Aberdeen.

PSYCHOLOGICAL TESTS

382. McFie, John (*National Hosp., Queen Sq., London, W.C. 1, Eng.*)

Psychological testing in clinical neurology. *J. Nerv. and Mental Dis.* Nov., 1960. 131:383-393.

Analysis of psychological data from 215 unselected patients with localized cerebral lesions and from 51 patients with lesions confirmed by pneumoencephalography indicated that certain intellectual abilities, including abstraction, are selectively impaired by lesions in different locations. Retention tests show similar impairment, according to the material to be retained. No transposition of laterality in intellectual functions was evident in any of the left-handed patients; a number of right-handed patients showed some ambiguity, if not of actual transposition, of laterality. Subtests of the Wechsler scales and tests of abstraction, retention, and learning were used. Dr. McFie suggests that identification of defined syndromes or patterns of impairment on psychological tests

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would be of more value to the neurologist than search for an indicator of "brain damage."

383. Weil, Paul G. (*Queen Mary Veterans Hosp., Montreal, Can.*)

The assessment and rehabilitation of the psychologically handicapped, by Paul G. Weil and A. G. Leblanc. *Med. Services J. (Canada)*. Oct., 1960. 16:9:765-772.

Describes a test developed at the Assessment and Rehabilitation Unit of Queen Mary Veterans Hospital, Montreal, to differentiate employable from unemployable among applicants applying for War Veterans Allowance. Results of the assessment methods with 120 veterans divided equally between the two categories have proved the reliability of the test to differentiate and also to predict the best employment prospects. Rehabilitation of the psychologically handicapped presents so many difficulties that reappraisal of rehabilitation programs in England, the U.S., and Canada was made. A comprehensive plan, embodying the best features of successful programs, is suggested.

RADIOGRAPHY

See 314.

READING

384. Cohn, Robert (*U.S. Naval Hosp., Bethesda 14, Md.*)

Delayed acquisition of reading and writing abilities in children; a neurological study. *Arch. Neurol.* Feb., 1961. 4:2:153-164.

Clinical neurological study of 46 children selected from a county school system for detailed investigation because of their failure to acquire reading and writing abilities revealed general disturbance in neurological function. Delayed development in the use of graphic symbols for communication was considered to be primarily an expression of this general disturbance. Re-examined neurologically (and electrically) 2 years after the initial study, 29 of the children, as a group, showed a general decrease in percentage of abnormalities as the result of training and increased chronological age, but improvement in no way compared favorably with a control series of children. It was noted that during the 2-year interval, no definite overall EEG "maturation" was evident in the abnormal subjects.

See also 325.

RECREATION

385. Connecticut. University. School of Home Economics

Play experiences handicapped mothers may share with young children, prepared by Jessie S. Wall. Storrs, Conn., The School (1961). 32 p. illus.

Another of the bulletins based on the School of Home Economics studies in "Work Simplification in the Area of Child Care for Physically Handicapped Women," (see *Rehab. Lit.*, this issue, #356). Suggested here are ways in which the handicapped mother can develop co-operative behavior in children and build trust through the sharing of play activities. Discussed are outdoor play supervised

from indoors, active indoor play, activities to bring the outdoors indoors, sharing musical experiences, creative art materials for children, and creative storytelling. A list of agencies supplying additional publications in special fields of interest is included.

Price lists of publications of the School of Home Economics are available from Handicapped Homemaker Research Center, School of Home Economics, University of Connecticut, Storrs, Conn.

REHABILITATION

386. International Society for Rehabilitation of the Disabled

Symposium: Selected papers presented at the Eighth World Congress of the . . . *J. Chronic Diseases*. Mar., 1961. 13:3:185-287.

Contents: Introduction, Howard A. Rusk (Special editor).—Rehabilitation and world peace, Howard A. Rusk.—Significant trends in the control of poliomyelitis and its sequelae, Gwendolyn Shepherd.—Current etiological concepts of cerebral palsy of postnatal origin, William A. Hawke.—Familial cerebral palsy, Emil Adler.—Parkinsonism, F. John Gillingham.—Problems of rehabilitation of the leprosy patient in a high prevalence area of Africa, M. F. Lechat and F. Puissant.—The speech behavior and language comprehension of autistic children, Wilbert Pronovost.—Current treatment methods and potentials of ongoing research in the field of muscular dystrophy, Karl G. Henriksson.—Cleft lip and cleft palate; clinical management and rehabilitation, Kerwin M. Marcks (and others).—Counseling parents of children with cleft lips and palates, D. C. Spriestersbach.—Problems of laryngectomees, Warren H. Gardner.—Rehabilitation for the disabled in Great Britain, S. A. S. Malkin.—The contribution of the handicapped to the world economy, Mary E. Switzer.—The role of the volunteer in program operation and development, Robert K. Mooney.

The *Proceedings* of the Congress (450 p.) will be available from the International Society for Rehabilitation of the Disabled, 701 First Ave., New York 17, N.Y. These papers, published only in the *Journal of Chronic Diseases*, will not appear in the *Congress Proceedings*.

See also p. 130; 318; 373; 374; 379; 383; 393.

REHABILITATION—CONNECTICUT

387. Johnson, Sarah C.

Better health services for the handicapped child: Part VI. The role of the physical therapist and occupational therapist in a crippled children's program. *Conn. Health Bul.* Feb., 1961. 75:2:45-49.

Previous articles in this series have discussed the need for integration of a variety of services in rehabilitating the handicapped. (See *Rehab. Lit.*, Apr., 1960, #296, for listing of first three articles.) Parts IV and V appeared in the April, 1960, issue (74:4:119-129) and the Sept., 1960, issue (74:9:263-268) of *Connecticut Health Bul.* and dealt respectively with the role of the medical social worker and the speech and hearing therapist in the crippled children's program.

The *Bulletin* is published monthly by the Connecticut State Department of Health, 165 Capitol Ave., Hartford 15, Conn.

REHABILITATION—SURVEYS

- 388. Muller, Jonas N.** (*1 E. 105th St., New York 29, N.Y.*)

Rehabilitation evaluation; some social and clinical problems. *Am. J. Public Health*. Mar., 1961. 51:3:403-409.

Describes a self-care evaluation form tested in a project in New York City to help determine when and to what extent rehabilitation services may be applicable to disabled older persons, especially the medically indigent in nursing homes who represent a public health problem. Despite the problems encountered, the author believes that reliable tests of ability to function in defined situations are appropriate measures of both patient status and the values of rehabilitation.

A copy of the self-care form, with general instructions and commands to be used in administering it, is available from the author on request.

REHABILITATION CENTERS—ADMINISTRATION

- 389. Stewart, Elizabeth Bryan** (*Rehabilitation Center, Salt Lake County General Hosp., 2033 S. State St., Salt Lake City 15, Utah*)

Organization and function of an outpatient alcoholic clinic in a general rehabilitation center, by Elizabeth Bryan Stewart (and others). *Am. J. Phys. Med.* Feb., 1961. 40:1:26-30.

Opened in 1957 as a demonstration project sponsored by the U.S. Office of Vocational Rehabilitation and the Utah State Board on Alcoholism, the Alcoholism Clinic of the University of Utah College of Medicine's Rehabilitation Center offers alcoholics and their families medical, psychological, psychiatric, social, and vocational counseling services. Such specialized services as neurology, physical and occupational therapy, and orthopedics are also available as needed. Evaluation technics have been developed and incorporated into the operation of the Center without detriment to alcoholic or physical medicine patients.

See also 320.

SCHOOL BUILDINGS

- 390. Fowles, Beth** (*Highland View Hosp., 3901 Ireland Dr., Cleveland 22, Ohio*)

Considerations for design and planning an elementary school for handicapped children and normal children. *Cerebral Palsy Rev.* Jan.-Feb., 1961. 22:1:3, 11.

A physical therapist with intimate knowledge of the physical limitations of handicapped children goes into considerable detail concerning adaptations needed in school buildings and equipment. It is recommended that the architect use the knowledge of therapists or a doctor of physical medicine in determining actual design of the building, equipment, and furniture.

See also 323.

SCOLIOSIS

See 315.

SHELTERED WORKSHOPS

- 391. Gellman, William** (*Jewish Vocational Service of Chicago, 231 S. Wells St., Chicago 4, Ill.*)

The vocational adjustment shop as an instrument for rehabilitating vocationally handicapped disabled persons. *Voc. Rehab. and Educ.*, U.S. Veterans Admin. July-Oct., 1960. 3 & 4:2-4, 26-28.

Objectives and design of the vocational adjustment shop differ from those of the sheltered workshop and occupational training shop. Environmental therapy and situational technics, supplementing the counseling process, are used to prepare the vocationally immature for competitive employment. Vocational development of "normal" and disabled persons is contrasted. The program of the Vocational Adjustment Center of the Jewish Vocational Service of Chicago, selected by the U.S. Office of Vocational Rehabilitation as a prototype for vocational adjustment shops, is described. Advantages and disadvantages of such shops in the rehabilitation of vocationally handicapped persons are discussed.

SHELTERED WORKSHOPS—ADMINISTRATION

- 392. Shulman, Owen J.** (*720 W. Douglas St., Wichita 12, Kan.*)

Differential use of casework services in the sheltered workshop. *J. Rehab.* Mar.-Apr., 1961. 27:2:30-32, 42-44.

Three case histories of clients provided with continued casework service during vocational rehabilitation illustrate the caseworkers' role in helping to bring about improved social functioning in both the working situation and the family and community groups. In addition to serving as a team member in the rehabilitation process, integrating services and clarifying the client's needs, the social worker participates in the individual therapy program, giving support and helping the patient to achieve motivation. Services are tailored to the individual's special problems and situation.

SOCIAL SERVICE—PROGRAMS

- 393. Berg, B. Robert** (*404 S. Eighth St., Minneapolis, Minn.*)

The use of regular community facilities for children with special needs. *Child Welfare*. Feb., 1961. 40:2: 12-15.

Where ideal community services are unavailable to meet the special needs of children, flexible use of existing resources permits the working out of sound programs of care. The writer includes case histories to illustrate how three separate organizations—an agency-operated resident camp, a half-day nursery school, and a small institution serving dependent and neglected children—broadened services to accept physically handicapped or emotionally disturbed children. All these facilities, designed to serve "normal" children, were able to meet special needs by using professional guidance and supervision provided by a caseworker from a family and children's service agency.

SPECIAL EDUCATION—EUROPE

See p. 140; 398.

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SPECIAL EDUCATION—RESEARCH

394. Newland, T. Ernest (*702 S. Race St., Urbana, Ill.*)

When the teacher researches, by T. Ernest Newland, Clyde J. Baer, and Raphael F. Simches. *Exceptional Children*. Feb., 1961. 27:6:299-301, 336.

Presents six basic rules for classroom research, prepared at the request of the Council for Exceptional Children's Research Committee. It is hoped that the observations will be of help to those studying problems in the classroom or school system that do not fall within the scope of major research.

SPECIAL EDUCATION— STUDY UNITS AND COURSES

395. Walker, Don L. (*Principal, Iowa Braille and Sight Saving School, 1002 G. Ave., Vinton, Iowa*)

The residential school as a student teaching center. *Internat. J. Educ. of the Blind*. Mar., 1961. 10:3:70-73.

For the past 3 years the Iowa Braille and Sight Saving School has served as a laboratory for the professional education of regular classroom teachers. The program provides excellent opportunity for recruitment of teachers of the visually handicapped, as well as a means of providing public school teachers with needed training and insight in the special problems of handicapped children.

SPEECH CORRECTION—GREAT BRITAIN

396. Morley, Muriel E. (*King's College, Durham Univ., Eng.*)

Speech therapy in Great Britain. *Asha*. Mar., 1961. 3:3:83-84.

A brief account of the growth of the profession in Great Britain, the organization of the College for Speech Therapists, which is the qualifying body for the profession, and the status of speech therapists under the National Health Service. Universities offering courses of study in speech and speech pathology are still few.

SPEECH CORRECTION—SOUTH AFRICA

397. Bauman, S. (*Dept. of Logopedics, Univ. of Witwatersrand, Johannesburg, S. Af.*)

Research needs in speech pathology in South Africa, by S. Bauman and M. Aron. *J. S. African Logopedic Soc.* Dec., 1960. 7:1:4-7.

Virtually no facilities exist in South Africa for the study and treatment of speech, voice, and hearing disabilities of non-Europeans. Before therapeutic efforts are undertaken, certain factors should be investigated—the influence of bilingualism and polyglotism on the incidence and nature of speech defects, cultural patterns and their relation to stuttering, the incidence of cleft palate among Africans, dysphonic problems and their causes, adaptive and compensatory mechanisms adopted by dysarthrics and dysphasics, hearing problems, and the possible need for different methods of teaching lip reading.

Possible cultural or socioeconomic factors influencing language development and the causes of reading and spelling difficulties among non-European populations are also suggested as unexplored fields for research. Educational institutions and government agencies should recognize the urgent need for initiating research projects.

See also 341.

SPEECH CORRECTION—U.S.S.R.

398. Clark, Ruth Millburn (*Speech Clinic, Univ. of Denver, Denver 10, Colo.*)

Speech pathology (logopedics) in the U.S.S.R. *Asha*. Feb., 1961. 3:2:43-45.

Observations on general and special education programs in the U.S.S.R., on training of special education teachers and speech correctionists, and on methods used in speech correction in Russian schools are based on a 1958 field study made by the Comparative Education Society of the United States. Research in the field is emphasized but is not as diversified or as advanced as in the United States. Theories on which treatment for stuttering and articulatory defects is based are discussed.

SPINAL CORD—MEDICAL TREATMENT

399. Sterling, Harold M. (*30 Warren St., Brighton 35, Mass.*)

Physical rehabilitation of young children with spinal cord lesions. *J. Am. Med. Assn.* Feb. 18, 1961. 175:7:584-587.

Early recognition and treatment of lesions can insure maximum recovery. Services of a number of medical specialists may be needed during the long-term care, but supervision of general care and modifications of treatment should be the responsibility of one physician. Adequate nutrition, exercises, and the prevention of complications are necessary for successful rehabilitation.

SPLINTS

400. Meyers, Marvin H. (*233 N. Prairie Ave., Inglewood, Calif.*)

A modern adjustable abduction splint, by Marvin H. Meyers and Robert W. Rogers. *Am. J. Phys. Med.* Feb., 1961. 40:1:1-4.

From the viewpoint of the physician, the Ortho-Aide abduction splint has several features to recommend it. Although not presented as a revolutionary new medical technic, it is considered an improvement over other types of abduction splints now in use. It has been used to treat a variety of conditions in more than 100 children ranging in age from 6 weeks to 8 years. Materials and construction are described and directions for mounting the splint on children's shoes are illustrated.

VOCATIONAL GUIDANCE

See 383; 391; 392.

Events and Comments

Hill-Burton Act Expenditures Approach \$5 Billion Mark

AS OF JANUARY 31, records showed that since 1954, under Part G of the Hill-Burton program, new beds in nursing homes totaled 14,792 and beds in chronic hospitals 6,451, while 165 rehabilitation facilities and 369 diagnostic or treatment centers received grants. Texas, Mississippi, New York, Pennsylvania, and Florida are leaders in this area of the program. Since 1946, under Part C, records showed 207,898 hospital beds and 967 public health centers have been completed or are in stages of development.

The Hill-Burton program to expand and improve hospitals represents a total expenditure in 15 years of \$4,723,633,000, the federal share being \$1,464,987,000. Nearly 70 percent of the 5,428 projects coming under the Act are completed and in operation.

Canadian Center Releases Statistics on Rehabilitation

AT THE WORKMEN'S COMPENSATION Board of Ontario Hospital and Rehabilitation Centre, admissions increased from 4,232 in 1959 to 4,284 during 1960. Of the 1960 admissions, 1,232 were in the Hospital Section and 3,052 in the Dormitory Section. Patients are sent to the Centre by the Head Office Medical Department according to criteria set up by the Rehabilitation and Treatment Services Committee. Injured workmen admitted to the Centre mainly are those who: 1) sustain major amputations; 2) live in areas where physical medicine facilities are not available or are quite limited in scope; 3) are not responding to local treatment; 4) require total rehabilitation or present problems; and 5) are to be physically appraised or given vocational aptitude testing.

By home address, patients come from: Metropolitan Toronto, 1,355; Northern Ontario (North Bay, Sudbury, Sault Ste. Marie, Timmins, Hearst, and Kirkland Lake), 983; London, Windsor, and Sarnia District, 878; Eastern District (Belleville, Kingston, Peterborough, Renfrew, Pembroke, and Ottawa), 478; Hamilton, Welland, and Niagara Falls District, 331; and Lakehead and northwestern Ontario District (Port Arthur and Fort William), 100. An additional 150 patients come from Quebec and other provinces.

Of the 4,275 discharged in 1960, ages ranged as follows: 31-40 years, 1,298; 41-50, 1,029; 21-30, 956; 51-60, 652;

61-70, 195; 20 and under, 130; and 71 and over, 15.

The average length of stay was 43.32 days, less than in a chronic disease hospital but greater than in a general hospital.

Of the 4,275 discharged, 72% were available for employment, 18% were temporary discharges, 8% were discharged for surgery, and 2% were premature discharges (*i.e.*, disciplinary reasons, absent without leave).

The prime objective of the Centre is to rehabilitate injured workmen for gainful employment. Of the total, 48% were returned at discharge to their former employment, 17% were returned to new employment, and the job prospects of 35% were unknown at the time. Those with minor disabilities were referred to the National Employment Service, and the field staff of the Vocational Rehabilitation Department followed up those with major disabilities. The group includes those receiving vocational retraining under the Vocational Rehabilitation Department. Of the group an additional 20 to 25% returned to employment in time. At discharge or a later date, 85 to 90% find employment.

Abilities Inc. of Florida Moves to Permanent Site

AT THE END OF MARCH, partial occupancy began in the new building of Abilities Inc. of Florida. The Hill-Burton Act made possible construction on the new site—10 acres of land just off Route 19 on the outskirts of St. Petersburg. Completion of the move vacates the rented space at Pinellis Park.

The new building houses electronics assembly work and a new direct mail advertising division. As the work load expands, the division will be serviced through a planned program for homebound disabled typists. The Human Resources Foundation will have substantial programs in research and teaching in the Florida operation.

Deputy Executive Director Appointed by NSCCA

CARL K. SCHMIDT has accepted the post of deputy executive director, National Society for Crippled Children and Adults, effective May 15. For the past 7½ years, Mr. Schmidt has been general superintendent of the Oak Forest Hospital of Cook County (Ill.), an outstanding facility for the care, treatment, and rehabilitation of the chronically ill and aged.

Arctic Rehabilitation Center Serves Handicapped Eskimos

AT THE SOUTHWEST CORNER of Baffin Island, located in the eastern Arctic, is a rehabilitation center for handicapped Eskimos. This Northern Affairs Department (Canada) center, started in 1957, now has 18 houses, 10 experimental homes, 10 styrofoam igloos, kitchen and dining hall, bath house and laundry, and facilities for various projects. The center was established to train Eskimos treated in southern hospitals to again become self-supporting. A large part of the Eskimo people presently are being treated for tuberculosis, and many will never again be fit for the hard life of hunting and trapping. They must be taught new skills for jobs less dangerous to health. Frobisher Bay, with an air base and with construction companies working in a new town, offers permanent employment to large numbers once they are trained in construction, carpentry, woodworking, mechanics, and other trades. In winter, 1,000 persons live at Frobisher Bay, 650 being Eskimos. With summer the population doubles. The rehabilitated Eskimo lives in a one-room cottage he has built with lumber supplied by the center and is encouraged to buy his home with earnings.

Change of Address

NATIONAL SOCIETY FOR THE PREVENTION OF BLINDNESS. To: 16 E. 40th St., New York City. (About June 1)

NSCCA Publishes New Pamphlets in Parent Series

AVAILABLE from the National Society for Crippled Children and Adults (2023 W. Ogden Ave., Chicago 12, Ill.) are two Easter Seal publications: *Growing Up: Cerebral Palsied Children Learn To Help Themselves*, by Mildred Shriner (Parent Series No. 7, 24 p., 25¢), and *On Being a Parent of a Handicapped Child*, by Benjamin Spock, M.D. (Parent Series No. 8, 18 p., 25¢). Mrs. Shriner, a pioneering teacher of the cerebral palsied, offers suggestions on simple technics and methods helpful in teaching the cerebral palsied child to dress himself, manage toilet needs, and care for his grooming. Dr. Spock considers the problems parents of a handicapped child face, offers practical suggestions, and tells where help may be found.

EVENTS AND COMMENTS

Chicago Schools' Study on Mentally Retarded Reported

THE FACTORS that determine classroom achievement and adjustment of the educable mentally handicapped child (IQ range 50-75) have been studied for four years by a research team for the Chicago Board of Education. The \$600,000 study was supported by grants from the U.S. Office of Education (*Cooperative Research Project SAE 6529*). Frances A. Mullen, Ph.D., the assistant superintendent in charge of special education of the Chicago schools, served as co-ordinator and William Itkin, Ph.D., as director of the project. It was observed that EMH children may not require special classes and in fact may progress further in the regular classroom.

The report just issued by Drs. Mullen and Itkin (*Chicago Board of Education, 228 N. LaSalle St., Chicago 1, Ill.*) describes the study and reports its findings and implications. Experimental teaching methods, tests, and evaluation devices developed and data on pupil characteristics are also reported in detail. The six parts of the mimeographed report on *How Mentally Handicapped Children Learn Under Classroom Conditions* are:

1. *Achievement and Adjustment of Educable Mentally Handicapped Children in Special Classes and in Regular grades.* 181 p.
2. *Teaching the Educable Mentally Handicapped Child: A Comparison of Four Methods of Instruction.* 37 p.
3. *The Chicago Test of General Information and General Comprehension for Educable Mentally Handicapped Children: Manual and Report.* 197 p.
4. *Personality Appraisal of Educable Mentally Handicapped Children: A System of Scoring and Interpreting Picture Story Tests.* 76 p.
5. *The Chicago Cooperative Research Project Practical Reading Test "Every Day Reading for Fun and Meaning": Directions for Administering and Scoring.* 2d ed. (various paging)
6. *Brief Screening Instruments for Evaluating the Academic Skills and Personal Adjustment of Educable Mentally Handicapped Children.* (various paging)

California Offers Course for Nursing Home Administrators

TO IMPROVE PATIENT CARE, the development of a training course for owners and administrators of nursing homes, sanitariums, rest homes, and homes for the aged has been contracted for by the California State Department of Public Health with the Attending Staff Association of Rancho Los Amigos Hospital in Los Angeles. A U.S. Public Health Service grant is providing funds for this \$50,000 project. John Gerletti, Ed.D., professor of public administration, on leave from the University

of Southern California, and C. C. Crawford, Ph.D., retired professor of education from the same university, will be responsible for the organization, administration, and evaluation of the project.

Plans call for the course, eventually to be given throughout the state, to include basic information in medicine, rehabilitation, nursing, mental hygiene, geriatrics, public health, hospital administration, and business management. More information can be obtained from Drs. Gerletti and Crawford at Rancho Los Amigos Hospital, 7601 E. Imperial Highway, Downey, Calif.

Book Award Goes to Dr. Beatrice Wright

THE ANNUAL BOOK AWARD of the Child Study Association for the best book written for parents and workers in family life education was presented to Beatrice A. Wright, Ph.D., for her book *Physical Disability—A Psychological Approach*. The award was made at the Association's annual conference held April 17th in New York City. The purpose of the award is to "encourage the publishing of sound books on child development and family life, as well as the purchasing of such books by parents and those who work with families." The Book Review Committee stated, "The profound insight which marks this book makes it a pioneering contribution to the literature on child development and family life." *Rehabilitation Literature*, in its Oct., 1960, issue gave special attention to Dr. Wright's book in the Review of the Month. Dr. Wright is the author of the Article of the Month for the January, 1961, issue.

An honorable mention award was given to Katherine Reeves for her book *Children . . . Their Ways and Wants*. Written for parents and teachers, this book describes the school life of the child from age 5 to 12.

Institute Held in New York On Housing for the Elderly

FEATURED SPEAKER at the opening session of the Institute on Producing Housing for Older People was Robert C. Weaver, the newly appointed administrator of the Housing and Home Finance Agency. Sponsored by the Institute of Physical Medicine and Rehabilitation of New York University Medical Center and the National Council on Aging, the Institute was held March 26 to 28 at the NYU Center before a group of builders and developers of homes for sale to older persons. The general chairman was Carl T. Mitnick. He is a past president of the National Association of Home Builders and president of the North Cape May Development Corporation, Collingswood, N. J. Three concurrent clinics on environmental planning offered help in solving practical problems arising in building houses for older persons.

W. C. Geer To Direct Council for Exceptional Children

EFFECTIVE JULY 1, William C. Geer has been appointed executive secretary of the Council for Exceptional Children. On that date Harley Z. Wooden, the Council's first executive secretary, will resign from the post after 11 years. Mr. Geer is now regional programs associate, Southern Regional Education Board, Atlanta, Ga. Previous positions held by him include heading the Board's Southern Regional Program in Education of Exceptional Children and supervising special education in the Nashville (Tenn.) public schools.

Bulova School Enrollment Higher

TOTAL ENROLLMENT in the watchmakers' and precision technician courses of the Joseph Bulova School of Watchmaking is now 94, the highest total in the school's history, except for a few years immediately after World War II, when many paraplegics and other disabled veterans swelled attendance to more than 200—in double shifts.

The Bulova school offers tuition-free courses to men disabled by paraplegia, poliomyelitis, amputation, or similar physical handicap. Courses usually run 18 months for watchmakers and 9 months for technicians, and students can board at the school's dormitory or in nearby homes at modest cost.

The school—the only one of its kind in the country—is located in Woodside, a residential section of New York City. More than 675 have been graduated since the school was founded in 1945.

Dr. Szasz Comments on

The Social Status of Names

"IF WE WERE to classify human beings—instead of their disembodied disabilities—into classes, according to which some would have more rights and opportunities than others (I am speaking here of legal rules, not of physical abilities to perform), then I think most physicians would hesitate to make any distinctions whatever. As matters still stand, however, certain disabilities are much more honorable—and hence more socially useful—than others. In other words, although society no longer recognizes aristocracies of birth, at least not in the forms in which these were honored in medieval monarchies, there are today aristocracies of illness. A residual paralysis from poliomyelitis, for example, ranks with the nobility; chronic peptic ulcer is on the level of the bourgeoisie; schizophrenia is slavery."—From "The Uses of Naming and the Origin of the Myth of Mental Illness," by Thomas S. Szasz, M.D., p. 59-65, in the February, 1961, issue of American Psychologist.

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